

2016 ESC Guidelines for the Management of Atrial Fibrillation Developed in Collaboration With EACTS

ESC Scientific Document Group; Kirchhof, Paulus; Benussi, Stefano; Kotecha, Dipak; Ahlsson, Anders; Atar, Dan; Casadei, Barbara; Castellá, Manuel; Diener, Hans-Christoph; Heidbuchel, Hein; Hendriks, Jeroen; Hindricks, Gerhard; Manolis, Antonis S; Oldgren, Jonas; Alexandru Popescu, Bogdan; Schotten, Ulrich; Van Putte, Bart; Vardas, Panagiotis

DOI:
[10.1016/j.rec.2016.11.033](https://doi.org/10.1016/j.rec.2016.11.033)

License:
Creative Commons: Attribution-NonCommercial-NoDerivs (CC BY-NC-ND)

Document Version
Peer reviewed version

Citation for published version (Harvard):
ESC Scientific Document Group, Kirchhof, P, Benussi, S, Kotecha, D, Ahlsson, A, Atar, D, Casadei, B, Castellá, M, Diener, H-C, Heidbuchel, H, Hendriks, J, Hindricks, G, Manolis, AS, Oldgren, J, Alexandru Popescu, B, Schotten, U, Van Putte, B & Vardas, P 2017, '2016 ESC Guidelines for the Management of Atrial Fibrillation Developed in Collaboration With EACTS', *Revista española de cardiología (English ed.)*, vol. 70, no. 1, pp. 50-50. <https://doi.org/10.1016/j.rec.2016.11.033>

[Link to publication on Research at Birmingham portal](#)

General rights

Unless a licence is specified above, all rights (including copyright and moral rights) in this document are retained by the authors and/or the copyright holders. The express permission of the copyright holder must be obtained for any use of this material other than for purposes permitted by law.

- Users may freely distribute the URL that is used to identify this publication.
- Users may download and/or print one copy of the publication from the University of Birmingham research portal for the purpose of private study or non-commercial research.
- User may use extracts from the document in line with the concept of 'fair dealing' under the Copyright, Designs and Patents Act 1988 (?)
- Users may not further distribute the material nor use it for the purposes of commercial gain.

Where a licence is displayed above, please note the terms and conditions of the licence govern your use of this document.

When citing, please reference the published version.

Take down policy

While the University of Birmingham exercises care and attention in making items available there are rare occasions when an item has been uploaded in error or has been deemed to be commercially or otherwise sensitive.

If you believe that this is the case for this document, please contact UBIRA@lists.bham.ac.uk providing details and we will remove access to the work immediately and investigate.

UNIVERSITY OF BIRMINGHAM

Research at Birmingham

2016 ESC Guidelines for the management of atrial fibrillation developed in collaboration with EACTS

Kirchhof, Paulus; Benussi, Stefano; Kotecha, Dipak; Ahlsson, Anders; Atar, Dan; Casadei, Barbara; Castella, Manuel; Diener, Hans-Christoph; Heidbuchel, Hein; Hendriks, Jeroen; Hindricks, Gerhard; Manolis, Antonis S; Oldgren, Jonas; Popescu, Bogdan Alexandru; Schotten, Ulrich; Van Putte, Bart; Vardas, Panagiotis; Authors/Task Force Members

DOI:

[10.1093/europace/euw295](https://doi.org/10.1093/europace/euw295)

License:

None: All rights reserved

Document Version

Peer reviewed version

Citation for published version (Harvard):

Kirchhof, P, Benussi, S, Kotecha, D, Ahlsson, A, Atar, D, Casadei, B, Castella, M, Diener, H-C, Heidbuchel, H, Hendriks, J, Hindricks, G, Manolis, AS, Oldgren, J, Popescu, BA, Schotten, U, Van Putte, B, Vardas, P & Authors/Task Force Members 2016, '2016 ESC Guidelines for the management of atrial fibrillation developed in collaboration with EACTS: The Task Force for the management of atrial fibrillation of the European Society of Cardiology (ESC). Developed with the special contribution of the European Heart Rhythm Association (EHRA) of the ESC. Endorsed by the European Stroke Organisation (ESO).' *Europace*. DOI: 10.1093/europace/euw295

[Link to publication on Research at Birmingham portal](#)

Publisher Rights Statement:

For internal use only; end product is available OA on ESC website

General rights

When referring to this publication, please cite the published version. Copyright and associated moral rights for publications accessible in the public portal are retained by the authors and/or other copyright owners. It is a condition of accessing this publication that users abide by the legal requirements associated with these rights.

- You may freely distribute the URL that is used to identify this publication.
- Users may download and print one copy of the publication from the public portal for the purpose of private study or non-commercial research.
- If a Creative Commons licence is associated with this publication, please consult the terms and conditions cited therein.
- Unless otherwise stated, you may not further distribute the material nor use it for the purposes of commercial gain.

Take down policy

If you believe that this document infringes copyright please contact UBIRA@lists.bham.ac.uk providing details and we will remove access to the work immediately and investigate.

UNIVERSITY OF BIRMINGHAM

The University of Birmingham
Research at Birmingham

2016 ESC Guidelines for the management of atrial fibrillation developed in collaboration with EACTS

Kirchhof, Paulus; Benussi, Stefano; Kotecha, Dipak; Ahlsson, Anders; Atar, Dan; Casadei, Barbara; Castella, Manuel; Diener, Hans-Christoph; Heidbuchel, Hein; Hendriks, Jeroen; Hindricks, Gerhard; Manolis, Antonis S; Oldgren, Jonas; Popescu, Bogdan Alexandru; Schotten, Ulrich; Van Putte, Bart; Vardas, Panagiotis; Authors/Task Force Members

DOI:

[10.1093/europace/euw295](https://doi.org/10.1093/europace/euw295)

Document Version

Peer reviewed version

Citation for published version (Harvard):

Kirchhof, P, Benussi, S, Kotecha, D, Ahlsson, A, Atar, D, Casadei, B, Castella, M, Diener, H-C, Heidbuchel, H, Hendriks, J, Hindricks, G, Manolis, AS, Oldgren, J, Popescu, BA, Schotten, U, Van Putte, B, Vardas, P & Authors/Task Force Members 2016, '2016 ESC Guidelines for the management of atrial fibrillation developed in collaboration with EACTS: The Task Force for the management of atrial fibrillation of the European Society of Cardiology (ESC) Developed with the special contribution of the European Heart Rhythm Association (EHRA) of the ESC Endorsed by the European Stroke Organisation (ESO)' *Europace*. DOI: 10.1093/europace/euw295

[Link to publication on Research at Birmingham portal](#)

Publisher Rights Statement:

For internal use only; end product is available OA on ESC website

General rights

When referring to this publication, please cite the published version. Copyright and associated moral rights for publications accessible in the public portal are retained by the authors and/or other copyright owners. It is a condition of accessing this publication that users abide by the legal requirements associated with these rights.

- You may freely distribute the URL that is used to identify this publication.
- Users may download and print one copy of the publication from the public portal for the purpose of private study or non-commercial research.
- If a Creative Commons licence is associated with this publication, please consult the terms and conditions cited therein.
- Unless otherwise stated, you may not further distribute the material nor use it for the purposes of commercial gain.

Take down policy

If you believe that this document infringes copyright please contact UBIRA@lists.bham.ac.uk providing details and we will remove access to the work immediately and investigate.

Download date: 27. Oct. 2016



2016 ESC Guidelines for the management of atrial fibrillation developed in collaboration with EACTS

The Task Force for the management of atrial fibrillation of the European Society of Cardiology (ESC)

Developed with the special contribution of the European Heart Rhythm Association (EHRA) of the ESC

Endorsed by the European Stroke Organisation (ESO)

Authors/Task Force Members: Paulus Kirchhof* (Chairperson) (UK/Germany), Stefano Benussi¹ (Co-Chairperson) (Switzerland), Dipak Kotecha (UK), Anders Ahlsson¹ (Sweden), Dan Atar (Norway), Barbara Casadei (UK), Manuel Castella Pericas¹ (Spain), Hans-Christoph Diener² (Germany), Hein Heidbuchel (Belgium), Jeroen Hendriks (The Netherlands), Gerhard Hindricks (Germany), Antonis S. Manolis (Greece), Jonas Oldgren (Sweden), Bogdan Alexandru Popescu (Romania), Ulrich Schotten (The Netherlands), Bart Van Putte¹ (The Netherlands), Panagiotis Vardas (Greece)

Document Reviewers: Stefan Agewall (CPG Review Coordinator) (Norway), John Camm (CPG Review Coordinator) (UK), Gonzalo Baron Esquivias (Spain), Werner Budts (Belgium), Scipione Carerj (Italy), Filip Casselman (Belgium), Antonio Coca (Spain), Raffaele De Caterina (Italy), Spiridon Deftereos (Greece), Dobromir Dobrev (Germany), José M. Ferro (Portugal), Gerasimos Filippatos (Greece), Donna Fitzsimons (UK), Bulent Gorenek (Turkey), Maxine Guenoun (France), Stefan H. Hohnloser (Germany), Philippe Kolh (Belgium), Gregory Y. H. Lip (UK), Athanasios Manolis (Greece), John Mc Murray (UK), Piotr Ponikowski (Poland), Raphael Rosenhek (Austria), Frank Ruschitzka (Switzerland), Irina Savelieva (UK), Sanjay Sharma (UK), Piotr Suwalski (Poland), Juan Luis Tamargo (Spain), Clare J. Taylor (UK), Isabelle C. Van Gelder (The Netherlands), Adriaan A. Voors (The Netherlands), Stephan Windecker (Switzerland), Jose Luis Zamorano (Spain), Katja Zeppenfeld (The Netherlands)

ESC Committee for Practice Guidelines (CPG) and National Cardiac Society Reviewers can be found in the Appendix

The disclosure forms of all experts involved in the development of these guidelines are available on the ESC website www.escardio.org/guidelines

Keywords:

Guidelines - Atrial fibrillation - Anticoagulation - Vitamin K antagonists - Non vitamin-K-antagonist oral anticoagulants - Left atrial appendage occlusion - Rate control - Cardioversion - Rhythm control - Antiarrhythmic drugs - Upstream therapy - Catheter ablation - AF surgery - Valve repair - Pulmonary vein isolation - Left atrial ablation

* Corresponding authors: Paulus Kirchhof, Institute of Cardiovascular Sciences, University of Birmingham, SWBH and UHB NHS trusts, IBR, Room 136, Wolfson Drive, Birmingham B152TT, United Kingdom. Tel: +44 121 4147042, E-mail: p.kirchhof@bham.ac.uk
Stefano Benussi, Department of Cardiovascular Surgery, University Hospital Zurich, Rämistrasse 100, 8091 Zurich, Switzerland Tel: +41(0)788933835, E-mail: stefano.benussi@usz.ch

¹Representing the European Association for Cardio-Thoracic Surgery (EACTS); ²Representing the

European Stroke Association (ESO)**ESC entities having participated in the development of this document:**

Associations: European Association of Cardiovascular Imaging (EACVI), European Heart Rhythm Association (EHRA), Heart Failure Association (HFA).

Councils: Council on Cardiovascular Nursing and Allied Professions

Working Groups: Cardiac Cellular Electrophysiology, Cardiovascular Pharmacotherapy

The content of these European Society of Cardiology (ESC) Guidelines has been published for personal and educational use only. No commercial use is authorized. No part of the ESC Guidelines may be translated or reproduced in any form without written permission from the ESC. Permission can be obtained upon submission of a written request to Oxford University Press, the publisher of the European Heart Journal and the party authorized to handle such permissions on behalf of the ESC (journals.permissions@oxfordjournals.org).

Disclaimer. The ESC Guidelines represent the views of the ESC and were produced after careful consideration of the scientific and medical knowledge and the evidence available at the time of their publication. The ESC is not responsible in the event of any contradiction, discrepancy and/or ambiguity between the ESC Guidelines and any other official recommendations or guidelines issued by the relevant public health authorities, in particular in relation to good use of healthcare or therapeutic strategies. Health professionals are encouraged to take the ESC Guidelines fully into account when exercising their clinical judgment, as well as in the determination and the implementation of preventive, diagnostic or therapeutic medical strategies; however, the ESC Guidelines do not override, in any way whatsoever, the individual responsibility of health professionals to make appropriate and accurate decisions in consideration of each patient's health condition and in consultation with that patient and, where appropriate and/or necessary, the patient's caregiver. Nor do the ESC Guidelines exempt health professionals from taking into full and careful consideration the relevant official updated recommendations or guidelines issued by the competent public health authorities, in order to manage each patient's case in light of the scientifically accepted data pursuant to their respective ethical and professional obligations. It is also the health professional's responsibility to verify the applicable rules and regulations relating to drugs and medical devices at the time of prescription.

© The European Society of Cardiology 2016. All rights reserved. For permissions please email: journals.permissions@oxfordjournals.org.

1	Table of Contents	
2	1 Preamble	10
3	2 Introduction	11
4	3 Epidemiology and impact for patients	11
5	3.1. Incidence and prevalence of atrial fibrillation.....	12
6	3.2. Morbidity, mortality, and healthcare burden of atrial fibrillation	12
7	3.3. Impact of evidence-based management on outcomes in atrial fibrillation patients.....	12
8	3.4. Gender.....	13
9	4 Pathophysiological and genetic aspects that guide management.....	14
10	4.1. Genetic predisposition.....	14
11	4.2. Mechanisms leading to atrial fibrillation.....	14
12	4.2.1. Remodelling of atrial structure and ion channel function.....	14
13	3.2.1. Electrophysiological mechanisms of atrial fibrillation.....	16
14	5 Diagnosis and timely detection of atrial fibrillation	17
15	5.1. Overt and silent atrial fibrillation	17
16	5.2. Screening for silent atrial fibrillation	17
17	5.2.1. Screening for atrial fibrillation by electrocardiogram in the community	17
18	5.2.2. Prolonged monitoring for paroxysmal atrial fibrillation.....	17
19	5.2.3. Patients with pacemakers and implanted devices	17
20	5.2.4. Detection of atrial fibrillation in stroke survivors	18
21	5.3. Electrocardiogram detection of atrial flutter	19
22	6 Classification of atrial fibrillation.....	19
23	6.1. Atrial fibrillation pattern	19
24	6.2. Atrial fibrillation types reflecting different causes of the arrhythmia	20
25	6.3. Symptom burden in atrial fibrillation.....	20
26	7 Detection and management of risk factors and concomitant cardiovascular diseases	21
27	7.1. Heart failure	22
28	7.1.1. Patients with atrial fibrillation and heart failure with reduced ejection fraction.....	23
29	7.1.2. Atrial fibrillation patients with heart failure with preserved ejection fraction.....	24
30	7.1.3. Atrial fibrillation patients with heart failure with mid-range ejection fraction.....	24
31	7.1.4. Prevention of atrial fibrillation in heart failure.....	25
32	7.2. Hypertension	25
33	7.2.1. Treatment of hypertension to prevent incident atrial fibrillation.....	25
34	7.2.2. Blood pressure control in patients with atrial fibrillation	25
35	7.3. Valvular heart disease	25
36	7.4. Diabetes mellitus.....	26
37	7.5. Obesity and weight loss	26
38	7.5.1. Obesity as a risk factor	26
39	7.5.2. Weight reduction in obese patients with atrial fibrillation	26
40	7.5.3. Catheter ablation in obese patients	26
41	7.6. Chronic obstructive pulmonary disease, sleep apnoea, and other respiratory diseases	26
42	7.7. Chronic kidney disease	27

43	8	Integrated management of patients with atrial fibrillation	28
44	8.1.	Evidence supporting integrated atrial fibrillation care	30
45	8.2.	Components of integrated atrial fibrillation care.....	30
46	8.2.1.	Patient involvement	30
47	8.2.2.	Multidisciplinary atrial fibrillation teams	31
48	8.2.3.	Role of non-specialists	31
49	8.2.4.	Technology use to support atrial fibrillation care	31
50	8.3.	Diagnostic workup of atrial fibrillation patients	31
51	8.3.1.	Recommended evaluation in all atrial fibrillation patients	31
52	8.3.2.	Additional investigations in selected patients with atrial fibrillation	32
53	8.4.	Structured follow-up	32
54	8.5.	Defining goals of atrial fibrillation management	32
55	9	Stroke prevention therapy in atrial fibrillation patients	33
56	9.1.	Prediction of stroke and bleeding risk	34
57	9.1.1.	Clinical risk scores for stroke and systemic embolism.....	34
58	9.1.2.	Anticoagulation in patients with a CHA ₂ DS ₂ -VASc score of 1 in men and 2 in women	35
59	9.1.3.	Clinical risk scores for bleeding	35
60	9.2.	Stroke prevention	36
61	9.2.1.	Vitamin K antagonists	36
62	9.2.2.	Non-vitamin K antagonist oral anticoagulants	37
63	9.2.3.	Non-vitamin K antagonist oral anticoagulants or vitamin K antagonists	40
64	9.2.4.	Oral anticoagulation in atrial fibrillation patients with chronic kidney disease.....	40
65	9.2.5.	Oral anticoagulation in atrial fibrillation patients on dialysis.....	41
66	9.2.6.	Patients with atrial fibrillation requiring kidney transplantation	41
67	9.2.7.	Antiplatelet therapy as an alternative to oral anticoagulants	41
68	9.3.	Left atrial appendage occlusion and exclusion.....	42
69	9.3.1.	Left atrial appendage occlusion devices	42
70	9.3.2.	Surgical left atrial appendage occlusion or exclusion	42
71	9.4.	Secondary stroke prevention	43
72	9.4.1.	Treatment of acute ischaemic stroke	43
73	9.4.2.	Initiation of anticoagulation after transient ischaemic attack or ischaemic stroke	43
74	9.4.3.	Initiation of anticoagulation after intracranial haemorrhage	44
75	9.5.	Strategies to minimize bleeding on anticoagulant therapy	46
76	9.5.1.	Uncontrolled hypertension	46
77	9.5.2.	Previous bleeding event.....	46
78	9.5.3.	Labile international normalized ratio and adequate non-vitamin K antagonist oral anticoagulant	
79	dosing	46	
80	9.5.4.	Alcohol abuse	46
81	9.5.5.	Falls and dementia.....	46
82	9.5.6.	Genetic testing	46
83	9.5.7.	Bridging periods off oral anticoagulation.....	47
84	9.6.	Management of bleeding events in anticoagulated patients with atrial fibrillation	47

85	9.6.1.	Management of minor, moderate, and severe bleeding.....	47
86	9.6.2.	Oral anticoagulation in atrial fibrillation patients at risk of or having a bleeding event.....	48
87	9.7.	Combination therapy with oral anticoagulants and antiplatelets.....	49
88	9.7.1.	Antithrombotic therapy after acute coronary syndromes and percutaneous coronary intervention	
89		in patients requiring oral anticoagulation.....	50
90	10	Rate control therapy in AF	52
91	10.1.	Acute rate control.....	52
92	10.2.	Long-term pharmacological rate control.....	53
93	10.2.1.	Beta-blockers.....	53
94	10.2.2.	Non-dihydropyridine calcium channel blockers.....	53
95	10.2.3.	Digitalis	53
96	10.2.4.	Amiodarone	54
97	10.3.	Heart rate targets in atrial fibrillation	54
98	10.4.	Atrioventricular node ablation and pacing	55
99	11	Rhythm control therapy in atrial fibrillation.....	57
100	11.1.	Acute restoration of sinus rhythm	57
101	11.1.1.	Antiarrhythmic drugs for acute restoration of sinus rhythm ('pharmacological cardioversion')	57
102	11.1.2.	'Pill in the pocket' cardioversion performed by patients.....	58
103	11.1.3.	Electrical cardioversion.....	59
104	11.1.4.	Anticoagulation in patients undergoing cardioversion	59
105	11.2.	Long-term antiarrhythmic drug therapy.....	59
106	11.2.1.	Selection of antiarrhythmic drugs for long-term therapy: Safety first!	60
107	11.2.2.	Twelve-lead electrocardiogram as a tool to identify patients at risk of proarrhythmia	61
108	11.2.3.	New antiarrhythmic drugs	63
109	11.2.4.	Antiarrhythmic effects of non-antiarrhythmic drugs.....	63
110	11.3.	Catheter ablation	65
111	11.3.1.	Indications	66
112	11.3.2.	Techniques and technologies.....	66
113	11.3.3.	Outcome and complications	66
114	11.3.4.	Anticoagulation – before, during, and after ablation.....	67
115	11.3.5.	Ablation of atrial fibrillation in heart failure patients.....	68
116	11.3.6.	Follow-up after catheter ablation.....	68
117	11.4.	Atrial fibrillation surgery	68
118	11.4.1.	Concomitant atrial fibrillation surgery	68
119	11.4.2.	Stand-alone rhythm control surgery	70
120	11.5.	Choice of rhythm control following treatment failure.....	71
121	11.6.	The atrial fibrillation Heart Team	71
122	12	Hybrid rhythm control therapy	73
123	12.1.	Combining antiarrhythmic drugs and catheter ablation	73
124	12.2.	Combining antiarrhythmic drugs and pacemakers	73
125	13	Specific situations.....	73
126	13.1.	Frail and 'elderly' patients	73

127	13.2. Inherited cardiomyopathies, channelopathies, and accessory pathways	74
128	13.2.1. Wolff–Parkinson–White syndrome	74
129	13.2.2. Hypertrophic cardiomyopathy	74
130	13.2.3. Channelopathies and arrhythmogenic right ventricular cardiomyopathy	75
131	13.3. Sports and atrial fibrillation.....	76
132	13.4. Pregnancy.....	76
133	13.4.1. Rate control	76
134	13.4.2. Rhythm control.....	76
135	13.4.3. Anticoagulation	77
136	13.5. Postoperative atrial fibrillation.....	77
137	13.5.1. Prevention of postoperative atrial fibrillation.....	77
138	13.5.2. Anticoagulation	78
139	13.5.3. Rhythm control therapy in postoperative atrial fibrillation	78
140	13.6. Atrial arrhythmias in grown-up patients with congenital heart disease	78
141	13.6.1. General management of atrial arrhythmias in grown-up patients with congenital heart disease	79
142	13.6.2. Atrial tachyarrhythmias and atrial septal defects.....	79
143	13.6.3. Atrial tachyarrhythmias after Fontan operation.....	79
144	13.6.4. Atrial tachyarrhythmias after tetralogy of Fallot correction	79
145	13.7. Management of atrial flutter.....	80
146	14 Patient involvement, education and self-management.....	81
147	14.1. Patient-centred care	81
148	14.2. Integrated patient education	81
149	14.3. Self-management and shared decision-making	81
150	15 Gaps in evidence.....	82
151	15.1. Major health modifiers causing atrial fibrillation.....	82
152	15.2. How much atrial fibrillation constitutes a mandate for therapy?	82
153	15.3. Atrial high-rate episodes and need for anticoagulation	82
154	15.4. Stroke risk in specific populations	82
155	15.5. Anticoagulation in patients with severe chronic kidney disease	82
156	15.6. Left atrial appendage occlusion for stroke prevention	82
157	15.7. Anticoagulation in atrial fibrillation patients after a bleeding or stroke event	82
158	15.8. Anticoagulation and optimal timing of non-acute cardioversion	83
159	15.9. Competing causes of stroke or transient ischaemic attack in atrial fibrillation patients.....	83
160	15.10. Anticoagulation in patients with biological heart valves (including transcatheter aortic valve	
161	implantation) and non-rheumatic valve disease.....	83
162	15.11. Anticoagulation after ‘successful’ catheter ablation	83
163	15.12. Comparison of rate control agents	83
164	15.13. Catheter ablation in persistent and long-standing persistent AF.....	83
165	15.14. Optimal technique for repeat catheter ablation	84
166	15.15. Combination therapy for maintenance of sinus rhythm	84
167	15.16. Can rhythm control therapy convey a prognostic benefit in atrial fibrillation patients?.....	84
168	15.17. Thoracoscopic ‘stand-alone’ atrial fibrillation surgery.....	84

169	15.18. Surgical exclusion of the left atrial appendage	84
170	15.19. Concomitant atrial fibrillation surgery.....	84
171	16 To do and not to do messages from the Guidelines	85
172	17 A short summary of the management of AF patients	88
173	18 Web Addenda	89
174	19 Appendix	89
175	20 References	90
176		
177		
178		
179		

180	Abbreviations and acronyms	
181	ABC	age, biomarkers, clinical history
182	ACE	angiotensin-converting enzyme
183	ACS	acute coronary syndromes
184	AF	atrial fibrillation
185	AFFIRM	Atrial Fibrillation Follow-up Investigation of Rhythm Management
186	AFNET	German Competence NETwork on Atrial Fibrillation
187	AHRE	atrial high rate episodes
188	ARB	angiotensin receptor blocker
189	ARISTOTLE	Apixaban for Reduction in Stroke and Other Thromboembolic Events in Atrial Fibrillation
190	ARNI	angiotensin receptor neprilysin inhibition
191	ATRIA	AnTicoagulation and Risk factors In Atrial fibrillation
192	AXAFA	Anticoagulation using the direct factor Xa inhibitor apixaban during Atrial Fibrillation
193		catheter Ablation: Comparison to vitamin K antagonist therapy
194	BAFTA	Birmingham Atrial Fibrillation Treatment of the Aged Study
195	BMI	body mass index
196	bpm	beats per minute
197	CABANA	Catheter Ablation versus Antiarrhythmic Drug Therapy for Atrial Fibrillation Trial
198	CAD	coronary artery disease
199	CHA ₂ DS ₂ -VASc	Congestive Heart failure, hypertension, Age ≥ 75 (doubled), Diabetes, Stroke (doubled),
200		Vascular disease, Age 65–74, and Sex (female)
201	CHADS ₂	Cardiac failure, Hypertension, Age, Diabetes, Stroke (Doubled)
202	CI	confidence interval
203	CKD	chronic kidney disease
204	CrCl	creatinine clearance
205	CT	computed tomography
206	DIG	Digitalis Investigation Group
207	EACTS	European Association for Cardio-Thoracic Surgery
208	EAST	Early treatment of Atrial fibrillation for Stroke prevention Trial
209	ECG	electrocardiogram/electrocardiography
210	EHRA	European Heart Rhythm Association
211	ENGAGE AF-TIMI 48	Effective Anticoagulation with Factor Xa Next Generation in Atrial Fibrillation–
212		Thrombolysis in Myocardial Infarction 48
213	EORP	EURObservational Research Programme
214	FAST	Atrial Fibrillation Catheter Ablation vs Surgical Ablation Treatment
215	FEV1	forced expiratory volume in 1 second
216	GDF-15	growth differentiation factor 15
217	GFR	glomerular filtration rate
218	GFR	glomerular filtration rate
219	GUCH	grown up congenital heart disease
220	HARMONY	A Study to Evaluate the Effect of Ranolazine and Dronedronone When Given Alone and in
221		Combination in Patients With Paroxysmal Atrial Fibrillation
222	HAS-BLED	hypertension, abnormal renal/liver function (1 point each), stroke, bleeding history or
223		predisposition, labile INR, elderly (>65 years), drugs/alcohol concomitantly (1 point each)
224	HFmrEF	heart failure with mid-range ejection fraction
225	HFpEF	heart failure with preserved ejection fraction
226	HFrfEF	heart failure with reduced ejection fraction
227	HR	hazard ratio
228	INR	international normalized ratio
229	LA	left atrium/atrial
230	LAA	left atrial appendage
231	LAAOS	Left Atrial Appendage Occlusion Study
232	LV	left ventricular
233	LVEF	left ventricular ejection fraction
234	LVH	left ventricular hypertrophy
235	MANTRA-PAF	Medical ANtiarrhythmic Treatment or Radiofrequency Ablation in Paroxysmal Atrial
236		Fibrillation
237	MERLIN	Metabolic Efficiency With Ranolazine for Less Ischemia in Non ST-Elevation Acute
238		Coronary Syndrome
239	MRI	magnetic resonance imaging

240	NOAC	non-vitamin K antagonist oral anticoagulant
241	NYHA	New York Heart Association
242	OAC	oral anticoagulation/oral anticoagulant
243	OR	odds ratio
244	ORBIT	Outcomes Registry for Better Informed Treatment of Atrial Fibrillation
245	PCI	percutaneous coronary intervention
246	PREVAIL	Prospective Randomized Evaluation of the Watchman LAA Closure Device In Patients with AF Versus Long Term Warfarin Therapy trial
247		
248	PROTECT AF	Watchman Left Atrial Appendage System for Embolic Protection in Patients With AF trial
249	PVI	pulmonary vein isolation
250	RACE	Rate Control Efficacy in Permanent Atrial Fibrillation
251	RATE-AF	Rate Control Therapy Evaluation in Permanent Atrial Fibrillation
252	RCT	randomized controlled trial
253	RE-CIRCUIT	Randomized Evaluation of dabigatran etexilate Compared to warfarin in pulmonaRy vein ablation: assessment of different peri-proCedUral anticoagulation sTrategies
254		
255	RE-LY	Randomized Evaluation of Long-Term Anticoagulation Therapy
256	ROCKET-AF	Rivaroxaban Once Daily Oral Direct Factor Xa Inhibition Compared with Vitamin K Antagonism for Prevention of Stroke and Embolism Trial in Atrial Fibrillation
257		
258	RR	risk ratio
259	SD	standard deviation
260	SPAF	Stroke Prevention in Atrial Fibrillation
261	TIA	transient ischaemic attack
262	TIMI	Thrombolysis In Myocardial Infarction
263	TOE	transoesophageal echocardiography
264	TTR	time in therapeutic range
265	UFH	unfractionated heparin
266	US	United States
267	VKA	vitamin K antagonist
268	WOEST	What is the Optimal antiplatElet and anticoagulant therapy in patients with oral anticoagulation and coronary StenTing
269		
270	WPW	Wolff-Parkinson-White syndrome
271		
272		

1 Preamble

Guidelines summarize and evaluate all available evidence on a particular issue at the time of the writing process, with the aim of assisting health professionals in selecting the best management strategies for an individual patient with a given condition, taking into account the impact on outcome, as well as the risk–benefit ratio of particular diagnostic or therapeutic means. Guidelines and recommendations should help health professionals to make decisions in their daily practice. However, the final decisions concerning an individual patient must be made by the responsible health professional(s) in consultation with the patient and caregiver as appropriate.

A great number of Guidelines have been issued in recent years by the European Society of Cardiology (ESC) and by the European Association for Cardio-Thoracic Surgery (EACTS), as well as by other societies and organisations. Because of the impact on clinical practice, quality criteria for the development of guidelines have been established in order to make all decisions transparent to the user. The recommendations for formulating and issuing ESC Guidelines can be found on the ESC website (<http://www.escardio.org/Guidelines-&-Education/Clinical-Practice-Guidelines/Guidelines-development/Writing-ESC-Guidelines>). ESC Guidelines represent the official position of the ESC on a given topic and are regularly updated.

Members of this Task Force were selected by the ESC, including representation from the European Heart Rhythm Association (EHRA), and EACTS as well as by the European Stroke Organisation (ESO) to represent professionals involved with the medical care of patients with this pathology. Selected experts in the field undertook a comprehensive review of the published evidence for management (including diagnosis, treatment, prevention and rehabilitation) of a given condition according to ESC Committee for Practice Guidelines (CPG) policy and approved by the EACTS and ESO. A critical evaluation of diagnostic and therapeutic procedures was performed, including assessment of the risk–benefit ratio. Estimates of expected health outcomes for larger populations were included, where data exist. The level of evidence and the strength of the recommendation of particular management options were weighed and graded according to predefined scales, as outlined in *Tables 1* and *2*.

The experts of the writing and reviewing panels provided declaration of interest forms for all relationships that might be perceived as real or potential sources of conflicts of interest. These forms were compiled into one file and can be found on the ESC website (<http://www.escardio.org/guidelines>). Any changes in declarations of interest that arise during the writing period must be notified to the ESC and EACTS and updated. The Task Force received its entire financial support from the ESC and EACTS without any involvement from the healthcare industry.

The ESC CPG supervises and coordinates the preparation of new Guidelines produced by task forces, expert groups or consensus panels. The Committee is also responsible for the endorsement process of these Guidelines. The ESC Guidelines undergo extensive review by the CPG and external experts, and in this case by EACTS and ESO-appointed experts. After appropriate revisions the Guidelines are approved by all the experts involved in the Task Force. The finalized document is approved by the CPG, EACTS and ESO for publication in the *European Heart Journal*, *Europace*, and in the *European Journal of Cardio-Thoracic Surgery* as well as in the *International Journal of Stroke (TBC)*. The Guidelines were developed after careful consideration of the scientific and medical knowledge and the evidence available at the time of their dating.

The task of developing ESC and EACTS Guidelines covers not only integration of the most recent research, but also the creation of educational tools and implementation programmes for the recommendations. To implement the guidelines, condensed pocket guideline versions, summary slides, booklets with essential messages, summary cards for non-specialists and an electronic version for digital applications (smartphones, etc.) are produced. These versions are abridged and thus, if needed, one should always refer to the full text version, which is freely available on the ESC website. The National Societies of the ESC are encouraged to endorse, translate and implement all ESC Guidelines. Implementation programmes are needed because it has been shown that the outcome of disease may be favourably influenced by the thorough application of clinical recommendations.

Surveys and registries are needed to verify that real-life daily practice is in keeping with what is recommended in the guidelines, thus completing the loop between clinical research, writing of guidelines, disseminating them and implementing them into clinical practice.

Health professionals are encouraged to take the ESC and EACTS Guidelines fully into account when exercising their clinical judgment, as well as in the determination and the implementation of preventive, diagnostic or therapeutic medical strategies. However, the ESC and EACTS Guidelines do not override in any way whatsoever the individual responsibility of health professionals to make appropriate and accurate decisions in consideration of each patient's health condition and in consultation with that patient and the patient's caregiver where appropriate and/or necessary. It is also the health professional's responsibility to verify the rules and regulations applicable to drugs and devices at the time of prescription.

333 **Table 1** Classes of recommendations

Table 1: Classes of Recommendations		
Classes of Recommendations	Definition	Suggested wording to use
Class I	Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective.	Is recommended/is indicated
Class II	Conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of the given treatment or procedure.	
Class IIa	Weight of evidence/opinion is in favour of usefulness/efficacy.	Should be considered
Class IIb	Usefulness/efficacy is less well established by evidence/opinion.	May be considered
Class III	Evidence or general agreement that the given treatment or procedure is not useful/effective, and in some cases may be harmful.	Is not recommended

334
335
336 **Table 2** Levels of evidence

Level of Evidence A	Data derived from multiple randomized clinical trials or meta-analyses.
Level of Evidence B	Data derived from a single randomized clinical trial or large non-randomized studies.
Level of Evidence C	Consensus of opinion of the experts and/or small studies, retrospective studies, registries.

337
338
339
340 **2 Introduction**

341 Despite good progress in the management of patients with atrial fibrillation (AF), this arrhythmia remains one of
342 the major causes of stroke, heart failure, sudden death, and cardiovascular morbidity in the world. Furthermore,
343 the number of patients with AF is predicted to rise steeply in the coming years. To meet the growing demand for
344 effective care of patients with AF, new information is continually generated and published, and the last few
345 years have seen substantial progress. It therefore seems timely to publish this 2nd edition of the ESC guidelines
346 on AF.

347
348 Reflecting the multidisciplinary input into the management of patients with AF, the Task Force includes
349 cardiologists with varying subspecialty expertise, cardiac surgeons, stroke neurologists, and specialist nurses
350 amongst its members. Supplementing the evidence review as outlined in the preamble, this task force identified
351 three PICOT questions on relevant topics for the guideline. The ESC commissioned external systematic reviews
352 to answer these three questions. These reviews informed specific recommendations.

353
354 Further to adhering to the standards for generating recommendations that is common to all ESC guidelines (see
355 preamble), this task force discussed each draft recommendation during web-based conference calls dedicated to
356 specific chapters, followed by consensus modifications and an online vote on each recommendation. Only
357 recommendations that were supported by at least 75% of the task force members were included in the guideline.

358
359 We hope that this guideline will help to deliver good care to all patients with AF based on the current state-of-
360 the-art evidence in 2016.

361
362 **3 Epidemiology and impact for patients**

3.1. Incidence and prevalence of atrial fibrillation

In 2010, the estimated numbers of men and women with atrial fibrillation (AF) worldwide were 20.9 million and 12.6 million, respectively, with higher incidence and prevalence rates in developed countries.^{1,2} One in four middle-aged adults in Europe and the United States (US) will develop AF.³⁻⁵ By 2030, 14–17 million AF patients are anticipated in the European Union, with 120,000–215,000 newly diagnosed patients per year.^{2,6,7} Estimates suggest an AF prevalence of approximately 3% in adults age 20 years or older,^{8,9} with more AF in elderly persons¹ and in patients with conditions such as hypertension, heart failure, coronary artery disease (CAD), valvular heart disease, diabetes mellitus, and chronic kidney disease (CKD).^{7,10-15} The increase in AF prevalence can be attributed to better detection of silent AF¹⁶⁻¹⁸ and increasing age and conditions predisposing to AF.¹⁹

3.2. Morbidity, mortality, and healthcare burden of atrial fibrillation

AF is independently associated with a twofold increased risk of all-cause mortality in women and a 1.5-fold increase in men²⁰⁻²² (Table 3). Death due to stroke can largely be mitigated by anticoagulation, while other cardiovascular deaths, for example due to heart failure and sudden death, remain common even in AF patients treated according to the current evidence-base.²³ AF is also associated with increased morbidity, such as heart failure and stroke.^{21,24,25} Contemporary studies show that 20–30% of patients with an ischaemic stroke have AF diagnosed before, during, or after the initial event.^{17,26,27} White matter lesions in the brain, cognitive impairment,²⁸⁻³⁰ decreased quality of life,^{31,32} and depressed mood³³ are common in AF patients, and between 10% and 40% of AF patients are hospitalized each year.^{23,34,35}

The direct costs of AF already amount to approximately 1% of total healthcare spending in the UK, and between \$6.0 and \$26.0 billion in the US for 2008,^{36,37} driven by AF-related complications (e.g. stroke) and AF-related treatment costs (e.g. hospitalizations). These costs will increase dramatically unless AF is prevented and treated in a timely and effective manner.

Table 3 Cardiovascular morbidity and mortality associated with AF

Event	Association with AF
Death	Increased mortality, especially cardiovascular mortality due to sudden death, heart failure, or stroke
Stroke	20–30% of all strokes are due to AF. A growing number of patients with stroke are diagnosed with ‘silent’, paroxysmal AF
Hospitalizations	10–40% of AF patients are hospitalized every year
Quality of life	Quality of life is impaired in AF patients independent of other cardiovascular conditions
LV dysfunction and heart failure	LV dysfunction is found in 20–30% of all AF patients. AF causes or aggravates LV dysfunction in many AF patients, while others have completely preserved LV function despite long-standing AF
Cognitive decline and vascular dementia	Cognitive decline and vascular dementia increase even in anticoagulated patients. Brain white matter lesions are more common in AF patients than in patients without AF

AF = atrial fibrillation; LV = left ventricular.

3.3. Impact of evidence-based management on outcomes in atrial fibrillation patients

Figure 1 depicts the major milestones in the management of AF. Despite these advances, substantial morbidity remains. Oral anticoagulation (OAC) with vitamin K antagonists (VKAs) or non-VKA oral anticoagulants (NOACs) markedly reduces stroke and mortality in AF patients.^{38,39} Other interventions such as rhythm control and rate control improve AF-related symptoms and may preserve cardiac function, but have not demonstrated a reduction in long-term morbidity or mortality.^{40,41}



Figure 1 Timeline of major landmarks in AF management, including treatment of concomitant conditions and prevention (green), anticoagulation (blue), rate and rhythm control (orange and red), and surgical therapy (purple).

ACEi = angiotensin-converting enzyme inhibitor; AF = atrial fibrillation; ARB = angiotensin receptor blocker; HF = heart failure; HFrEF = heart failure with reduced ejection fraction; LVH = left ventricular hypertrophy; NOAC = non-vitamin K antagonist oral anticoagulant; PUFA = polyunsaturated fatty acid; PVI = pulmonary vein isolation; QoL = quality of life; RACE = Rate Control Efficacy in Permanent Atrial Fibrillation; RF = radiofrequency; SR = sinus rhythm; VKA = vitamin K antagonist.

In contemporary, well-controlled, randomized clinical trials in AF, the average annual stroke rate is about 1.5% and the annualized death rate is around 3%.⁴⁰ In real life, the annual mortality can be different (both higher and lower).⁴² A minority of these deaths are related to stroke, while sudden cardiac death and death from progressive heart failure are more frequent, emphasizing the need for interventions beyond anticoagulation.^{43, 44}

Furthermore, AF is also associated with high rates of hospitalization, commonly for AF management, but often also for heart failure, myocardial infarction, and treatment-associated bleeding.^{34, 45}

3.4. Gender

In both developed and developing countries, the age-adjusted incidence and prevalence of AF are lower in women, while the risk of death in women with AF is similar to or higher than that in men with AF.^{1, 46, 47} Female AF patients who have additional stroke risk factors (particularly older age) are also at greater risk than men of having a stroke,^{48, 49} even those anticoagulated with warfarin⁵⁰ (see Chapter 8 for details). Women with diagnosed AF can be more symptomatic than men and are typically older with more comorbidities.^{51, 52} Bleeding risk on anticoagulation is similar in both sexes,^{49, 50, 53} but women appear less likely to receive specialist care and rhythm control therapy,⁵⁴ while the outcomes of catheter ablation or AF surgery are comparable to those in men.^{55, 56} These observations highlight the need to offer effective diagnostic tools and therapeutic management equally in women and men.

Recommendations relating to gender

Recommendations	Class ^a	Level ^b	Refs ^c
AF clinicians must offer effective diagnostic tools and therapeutic management to women and men equally to prevent stroke and death	I	A	39, 46, 57
Catheter or surgical ablation techniques should be regarded as equally effective in women and men	Ila	B	55, 56

428

AF = atrial fibrillation

429

^aClass of recommendation.

430

^bLevel of evidence.

431

^cReference(s) supporting recommendations.

432

433

4 Pathophysiological and genetic aspects that guide management

434

4.1. Genetic predisposition

435

AF, especially early-onset AF, has a strong heritable component, independent of concomitant cardiovascular

436

conditions.^{58,59} A few young AF patients suffer from inherited cardiomyopathies or channelopathies mediated

437

by disease-causing mutations. These monogenic diseases also convey a risk for sudden death (see Chapter 5).

438

Up to one-third of AF patients carry common genetic variants that predispose to AF, albeit with a relatively low

439

added risk. At least 14 of these common variants, often single nucleotide polymorphisms, are known to increase

440

the risk of prevalent AF in populations.⁶⁰⁻⁶² The most important variants are located close to the paired-like

441

homeodomain transcription factor 2 gene on chromosome 4q25.^{63,64} These variants modify the risk of AF up to

442

sevenfold.⁶⁴ Several of the AF risk variants are also associated with cardioembolic or ischaemic stroke, possibly

443

due to silent AF (see section 4.1).^{62,65,66} Changes in atrial action potential characteristics,⁶⁷⁻⁷⁰ atrial remodelling,

444

and modified penetration of rare gene defects⁶¹ have been suggested as potential mechanisms mediating

445

increased AF risk in carriers of common gene variants. Genetic variants could in the future become useful for

446

patient selection of rhythm control strategies,⁷¹⁻⁷³ but it is currently unknown whether common gene variants

447

differentially affect the efficacy of antiarrhythmic drugs or rate control medication.⁷⁴ While genomic analysis

448

may provide an opportunity to improve diagnosis and management of AF in the future,^{75,76} routine genetic

449

testing for common gene variants associated with AF cannot be recommended at present.⁷⁷

450

451

4.2. Mechanisms leading to atrial fibrillation

452

4.2.1. Remodelling of atrial structure and ion channel function

453

External stressors such as structural heart disease, hypertension, possibly diabetes, but also AF itself induce a

454

slow but progressive process of structural remodelling in the atria (*Figure 2*). Activation of fibroblasts,

455

enhanced connective tissue deposition, and fibrosis are the hallmarks of this process.⁷⁸⁻⁸⁰ In addition, atrial fatty

456

infiltration, inflammatory infiltrates, myocyte hypertrophy, necrosis, and amyloidosis are found in AF patients

457

with concomitant conditions predisposing to AF.⁸¹⁻⁸⁴ Structural remodelling results in electrical dissociation

458

between muscle bundles and local conduction heterogeneities,⁸⁵ favouring reentry and perpetuation of the

459

arrhythmia.⁸⁶ In many patients, the structural remodelling process occurs before the onset of AF.⁷⁸ As some of

460

the structural remodelling will be irreversible, early initiation of treatment seems desirable.⁸⁷ *Table 4* gives an

461

overview of the most relevant pathophysiological alterations in atrial tissue associated with AF, and lists

462

corresponding clinical conditions that can contribute to these changes.

463

The functional and structural changes in atrial myocardium and stasis of blood, especially in the left

464

atrial appendage (LAA), generate a prothrombotic milieu. Furthermore, even short episodes of AF lead to

465

myocardial damage and expression of prothrombotic factors on the atrial endothelial surface, and activation of

466

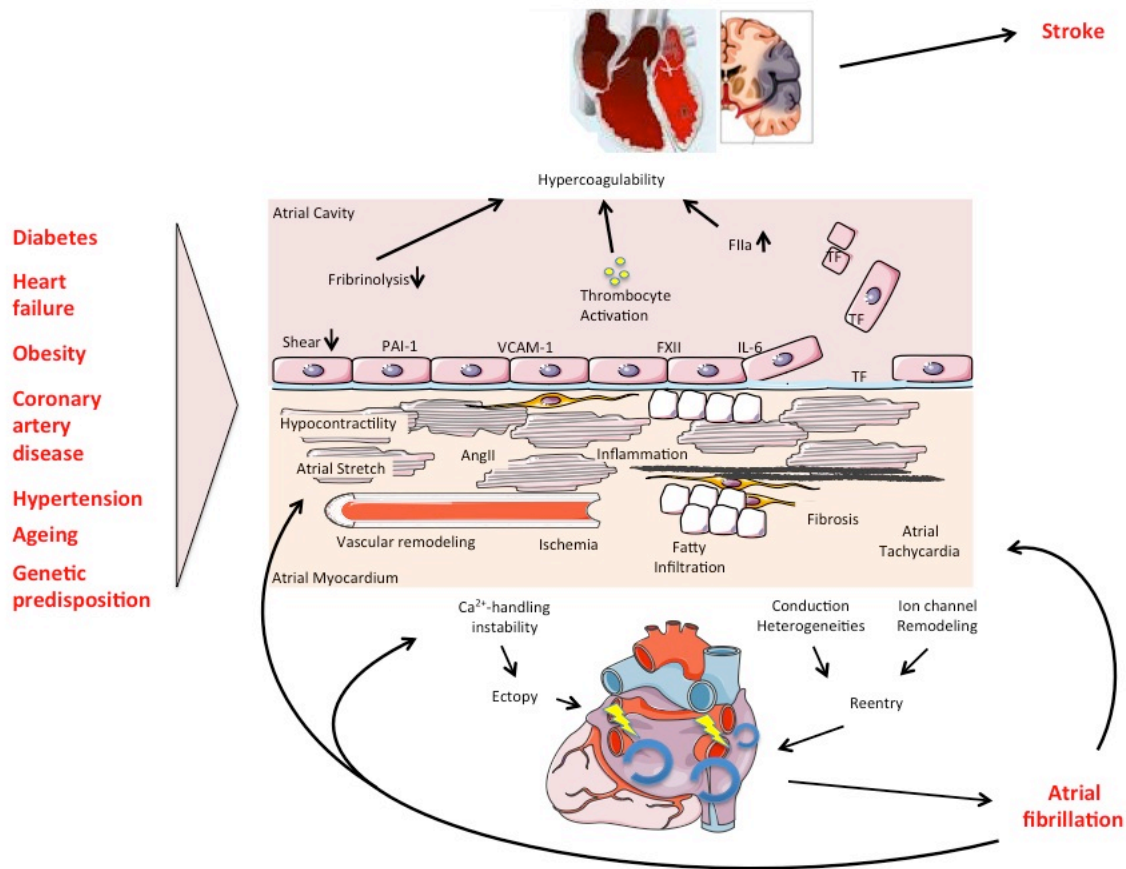
platelets and inflammatory cells, and contribute to a generalized prothrombotic state.^{88,89} The atrial and

467

systemic activation of the coagulation system can partially explain why short episodes of AF convey a long-

468

term stroke risk.



469
470

Figure 2 Major mechanisms causing AF that can be considered when guiding therapy. The various aetiological factors (left) cause a complex array of pathophysiological changes in the atria, including stretch-induced atrial fibrosis, hypocontractility, fatty infiltration, inflammation, vascular remodelling, ischaemia, ion channel dysfunction, and Ca²⁺-instability. These changes enhance both ectopy and conduction disturbances, increasing the propensity of the atria to develop or maintain AF. At the same time, some of these alterations are involved in the occurrence of the hypercoagulable state associated with AF. For example, hypocontractility reduces local endothelial shear stress, which increases PAI-1 expression, and ischaemia-induced inflammation enhances the expression of endothelial adhesion molecules or promotes shedding of endothelial cells, resulting in tissue factor exposure to the blood stream. These changes contribute to the thrombogenic milieu in the atria of AF patients. AF in itself can aggravate many of the mechanisms shown, which may explain the progressive nature of the arrhythmia. AngII = angiotensin II; TF = tissue factor; FXII = factor XII; IL-6 = interleukin 6; PAI-1 = plasminogen activator inhibitor 1; VCAM-1 = vascular cell adhesion molecule 1.

484
485
486
487

Table 4 Pathophysiological alterations in atrial tissue associated with AF and clinical conditions that could contribute to such alterations

Pathophysiological alteration	Clinical conditions contributing to the alteration	Proarrhythmic mechanism/functional consequence	References
<i>Changes of the extracellular matrix, fibroblast function, and fat cells</i>			
Interstitial and replacement fibrosis	AF (especially forms with a high AF burden), hypertension, heart failure, valvular heart disease (via pressure and volume overload)	Electrical dissociation, conduction block, enhanced AF complexity	78, 79, 90, 91
Inflammatory infiltration		Profibrotic responses, enhanced AF complexity	81
Fatty infiltration	Obesity (fatty infiltration)	Profibrotic/proinflammatory responses, localized conduction	82, 92

Amyloid deposition	Ageing, heart failure, CAD (via atrial scarring), genetic factors	block Conduction disturbances	83, 93
<i>Ion channel alterations</i>			
Ion channel remodelling	AF (especially forms with a high AF burden), genetic predisposition to AF	AF cycle shortening (if due to atrial tachycardia), AF cycle length prolongation (if due to heart failure), enhanced heterogeneity of atrial repolarization	94-96
Ca ²⁺ handling instability	AF (especially forms with a high AF burden), possibly heart failure and hypertension (possibly through increased sympathetic activation)	Enhanced propensity to ectopy	97, 98
Gap-junction redistribution	AF	Conduction disturbances	99
<i>Myocyte alterations</i>			
Apoptosis and necrosis	CAD, heart failure (through cardiomyocyte death and atrial scarring)	May induce replacement fibrosis	100
Myocyte hypertrophy	Atrial dilatation, AF	Aggravates conduction disturbances	84, 101
<i>Endothelial and vascular alterations</i>			
Microvascular changes	Atherosclerosis, CAD and peripheral artery disease, possibly AF	Aggravation of atrial ischaemia, heterogeneity of electrical function, structural remodelling	102
Endocardial remodelling		Enhanced risk for thrombus formation	103, 104
<i>Changes of the autonomic nervous system</i>			
Sympathetic hyperinnervation	Heart failure, hypertension	Enhanced propensity to ectopy	80, 105

488 AF = atrial fibrillation; CAD = coronary artery disease.

489

490 3.2.1. Electrophysiological mechanisms of atrial fibrillation

491 AF provokes a shortening of the atrial refractory period and AF cycle length during the first days of the
 492 arrhythmia, largely due to downregulation of the Ca²⁺-inward current and upregulation of inward rectifier K⁺
 493 currents.^{94, 95} Structural heart disease, in contrast, tends to prolong the atrial refractory period, illustrating the
 494 heterogeneous nature of mechanisms that cause AF in different patients.⁹⁶ Hyperphosphorylation of various
 495 Ca²⁺ handling proteins may contribute to enhanced spontaneous Ca²⁺ release events and triggered activity,^{97, 98}
 496 thus causing ectopy and promoting AF. Although the concept of Ca²⁺ handling instability has been challenged
 497 recently,^{106, 107} it may mediate AF in structurally remodelled atria and explain how altered autonomic tone can
 498 generate AF.^{80, 105}

499

500 ***Focal initiation and maintenance of AF:*** The seminal observation by Haissaguerre et al¹⁰⁸ was that a focal
 501 source in the pulmonary veins can trigger AF, and ablation of this source can extinguish the arrhythmia. The
 502 mechanism of focal activity might involve both triggered activity and localized reentry.^{109, 110} Hierarchic
 503 organization of AF with rapidly activated areas driving the arrhythmia has been documented in patients with
 504 paroxysmal AF,^{111, 112} but is more challenging in patients with persistent AF.¹¹³

505

506 ***The multiple wavelet hypothesis and rotors as sources of AF:*** Moe and Abildskov¹¹⁴ proposed that AF can be
 507 perpetuated by continuous conduction of several independent wavelets propagating through the atrial
 508 musculature in a seemingly chaotic manner. As long as the number of wavefronts does not decline below a
 509 critical level, they will be capable of sustaining the arrhythmia. Numerous experimental and clinical
 510 observations can be reconciled with the multiple wavelet hypothesis.¹¹⁵ All localized sources of AF (ectopic

511 foci, rotors, or other stable reentry circuits) cause fibrillatory conduction remote from the source, which is
512 difficult to distinguish from propagation sustaining AF by multiple wavelets, and either of these phenomena
513 may generate ‘rotors’ picked up by intracardiac^{116,117} or body surface¹¹⁷ recordings.
514
515

516 **5 Diagnosis and timely detection of atrial fibrillation**

517 **5.1. Overt and silent atrial fibrillation**

518 The diagnosis of AF requires rhythm documentation using an electrocardiogram (ECG), with the typical pattern
519 of AF. ECG-documented AF was the entry criterion in trials forming the evidence for these guidelines. By
520 accepted convention, an episode lasting at least 30 seconds is diagnostic. Individuals with AF may be
521 symptomatic or asymptomatic (‘silent AF’). Many AF patients have both symptomatic and asymptomatic
522 episodes of AF.¹¹⁸⁻¹²¹

523 Silent, undetected AF is common,^{120, 122} with severe consequences such as stroke and death.¹²³⁻¹²⁵
524 Prompt recording of an ECG is an effective and cost-effective method to document chronic forms of AF.¹²⁶ The
525 technology to detect paroxysmal, self-terminating AF episodes is rapidly evolving (see Chapter 5 for a
526 definition of AF patterns). There is good evidence that prolonged ECG monitoring enhances the detection of
527 undiagnosed AF, for 72 hours after a stroke,^{27, 127} for even longer periods,^{18, 128} or by daily short-term ECG
528 recording in patients over 75 years of age¹²⁹ (*Web Addenda Figure 1*). Ongoing studies will determine whether
529 such early detection alters management (e.g. initiation of anticoagulation) and improves outcomes.

530 Once the ECG diagnosis of AF has been established, further ECG monitoring can inform management
531 in the context of: (1) a change in symptoms or new symptoms; (2) suspected progression of AF; (3) monitoring
532 of drug effects on ventricular rate; and (4) ECG monitoring of antiarrhythmic drug effects or catheter ablation
533 for rhythm control.
534

535 **5.2. Screening for silent atrial fibrillation**

536 **5.2.1. Screening for atrial fibrillation by electrocardiogram in the community**

537 Undiagnosed AF is common, especially in older populations and in patients with heart failure.¹³⁰ Opportunistic
538 screening for silent AF seems cost-effective in elderly populations (e.g. > 65 years),¹³¹ and similar effects have
539 been reported using single-lead ECG screening in other at-risk populations.^{132, 133} Screening of elderly
540 populations (mean age 64 years) yielded a prevalence of 2.3% for chronic forms of AF in 122,571 participants
541 using either short-term ECG or pulse palpation (followed by ECG in those with an irregular pulse).¹³⁴
542 Previously undiagnosed AF was found in 1.4% of those aged > 65 years, suggesting a number needed to screen
543 of 70. These findings encourage the further evaluation of systematic AF screening programmes in at-risk
544 populations.
545

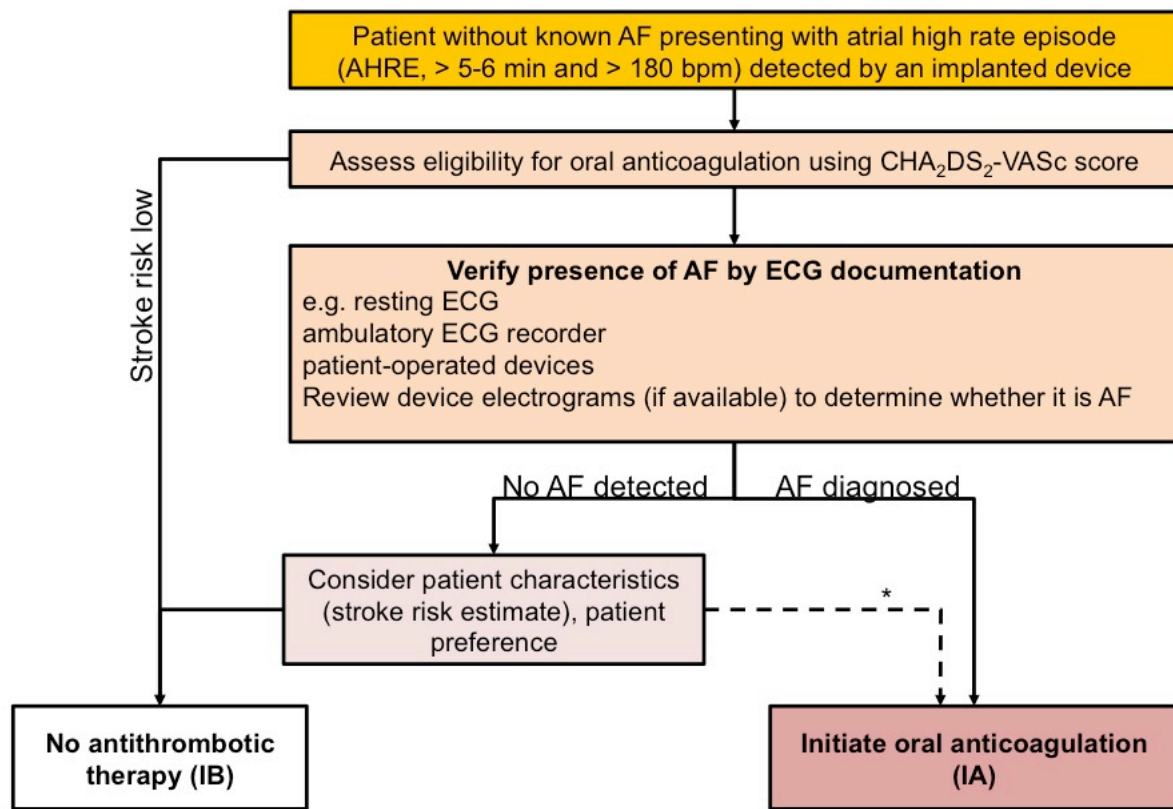
546 **5.2.2. Prolonged monitoring for paroxysmal atrial fibrillation**

547 Paroxysmal AF is often missed.¹²⁰ Repeated daily ECG recordings increased the detection of silent,
548 asymptomatic paroxysmal AF in an unselected Swedish population aged > 75 years.^{120, 135} Several patient-
549 operated devices^{136, 137} and extended continuous ECG monitoring using skin patch recorders¹³⁸ have been
550 validated for detection of paroxysmal AF.¹³⁹ The detection rate of asymptomatic AF by new technologies such
551 as smartphone cases with ECG electrodes, smart watches, and blood pressure machines with AF detection
552 algorithms, has not yet been formally evaluated against an established arrhythmia detection method.¹⁴⁰
553

554 **5.2.3. Patients with pacemakers and implanted devices**

555 Implanted pacemakers or defibrillators with an atrial lead allow continuous monitoring of atrial rhythm. Using
556 this technology, patients with atrial high rate episodes (AHRE) can be identified. Depending on the risk profile
557 of the population studied, such AHRE are detected in 10–15% of pacemaker patients.¹⁴¹ AHRE are associated
558 with an increased risk of overt AF (hazard ratio [HR] 5.56; 95% confidence interval [CI] 3.78–8.17; $P < 0.001$)
559 and ischaemic stroke or systemic embolism (HR 2.49; 95% CI 1.28–4.85; $P = 0.007$). The stroke risk in AHRE
560 patients seems lower than the stroke risk in patients with diagnosed AF, and not all AHRE represent AF.¹⁴²
561 Strokes often occur without AHRE detected within 30 days before the event.¹⁴³⁻¹⁴⁷ Consequently, it is unclear
562 whether AHRE imply the same therapeutic requirements as overt AF,¹⁴⁸ and the benefit of OAC in patients with
563 AHRE is being evaluated in ongoing clinical trials (e.g. ARTESiA [NCT01938248] and NOAH
564 [NCT02618577]). At present, pacemakers and implanted devices should be interrogated on a regular basis for
565 AHRE, and patients with AHRE should undergo further assessment of stroke risk factors and for overt AF,

566 including ECG monitoring (Figure 3).¹⁴⁹



*In rare individual circumstances, oral anticoagulation may be considered in patients with AHRE, but without diagnosed AF. This clearly needs discussion with the patient and careful evaluation of perceived benefit and risk.

567 **Figure 3** Management of AHRE detected on an implanted device. Adapted from the report of the 3rd
568 AFNET/EHRA consensus conference.¹⁵⁰

569 AF = atrial fibrillation; AFNET = German Competence NETwork on Atrial Fibrillation; AHRE = atrial high
570 rate episodes; bpm = beats per minute; CHA₂DS₂-VASc = Congestive Heart failure, hypertension, Age ≥75
571 (doubled), Diabetes, Stroke (doubled), Vascular disease, Age 65–74, and Sex (female); ECG =
572 electrocardiogram; EHRA = European Heart Rhythm Association.
573

574 **5.2.4. Detection of atrial fibrillation in stroke survivors**

576 Sequential stratified ECG monitoring detected AF in 24% (95% CI 17–31) of stroke survivors,¹⁵¹ and in 11.5%
577 (95% CI 8.9%–14.3%) in another meta-analysis,¹⁷ with large variations depending on the timing, duration, and
578 method of monitoring. AF detection is not uncommon in unselected stroke patients (6.2%, 95% CI 4.4–8.3),¹²⁸
579 but is more likely in patients with cryptogenic stroke implanted with loop recorders or who have had ECG
580 monitors for several weeks.^{18, 128, 152} Cryptogenic stroke is defined as a stroke in which the cause could not be
581 identified after extensive investigations.¹⁵³ A broader definition is embolic stroke of undetermined source.¹⁵⁴
582 Several studies have also found AF in patients in whom another competing cause for stroke has been identified
583 clinically (e.g. hypertension or carotid artery stenosis).^{27, 127} Hence, prolonged ECG monitoring seems
584 reasonable in all survivors of an ischaemic stroke without an established diagnosis of AF.
585

586 **Recommendations for screening for AF**

Recommendations	Class ^a	Level ^b	Refs ^c
Opportunistic screening for AF is recommended by pulse taking or ECG rhythm strip in patients > 65 years of age	I	B	130, 134, 155
In patients with TIA or ischaemic stroke, screening for AF is recommended by short-term ECG recording followed by continuous ECG monitoring for at least 72 hours	I	B	27, 127

It is recommended to interrogate pacemakers and ICDs on a regular basis for atrial high rate episodes (AHRE). Patients with AHRE should undergo further ECG monitoring to document AF before initiating AF therapy	I	B	141, 156
In stroke patients, additional ECG monitoring by long-term non-invasive ECG monitors or implanted loop recorders should be considered to document silent AF	IIa	B	18, 128
Systematic ECG screening may be considered to detect AF in patients aged > 75 years, or those at high stroke risk	IIb	B	130, 135, 157

587 AF = atrial fibrillation; AHRE = atrial high rate episodes; ECG = electrocardiogram; ICD = implantable
588 cardioverter defibrillator; TIA = transient ischaemic attack.

589 ^aClass of recommendation.

590 ^bLevel of evidence.

591 ^cReference(s) supporting recommendations.

592

593 5.3. Electrocardiogram detection of atrial flutter

594 Right atrial isthmus-dependent flutter has a typical ECG pattern and ventricular rate.¹⁵⁸ The prevalence of atrial
595 flutter is less than one-tenth of the prevalence of AF.¹⁵⁹ Atrial flutter often coexists with or precedes AF.¹⁶⁰ In
596 typical, isthmus-dependent flutter, P waves will often show a 'saw tooth' morphology, especially in the inferior
597 leads (II, III, aVF). The ventricular rate can be variable (usual ratio of atrial to ventricular contraction 4:1 to 2:1,
598 in rare cases 1:1) and macro-reentrant tachycardias may be missed in stable 2:1 conduction. Vagal stimulation
599 or intravenous adenosine may be helpful to unmask atrial flutter. The management of atrial flutter is discussed
600 in Section 12.7. Left or right atrial macro-reentrant tachycardia is usually confined to patients after catheter
601 ablation for AF, AF surgery, or after open heart surgery.¹⁵⁸

602

603 6 Classification of atrial fibrillation

604 6.1. Atrial fibrillation pattern

605 In many patients, AF progresses from short, infrequent episodes to longer and more frequent attacks. Over time,
606 many patients will develop sustained forms of AF. In a small proportion of patients, AF will remain paroxysmal
607 over several decades (2–3% of AF patients).¹⁶¹ The distribution of paroxysmal AF recurrences is not random,
608 but clustered.¹⁶² AF may also regress from persistent to paroxysmal AF. Furthermore, asymptomatic recurrences
609 of AF are common in patients with symptomatic AF.¹²⁰

610

611 Based on presentation, duration, and spontaneous termination of AF episodes, five types of AF are
612 traditionally distinguished: first diagnosed, paroxysmal, persistent, long-standing persistent, and permanent AF
613 (*Table 5*). If patients suffer from both paroxysmal and persistent AF episodes, the more common type should be
614 used for classification. Clinically determined AF patterns do not correspond well to the AF burden measured by
615 long-term ECG monitoring.¹⁶³ Even less is known about the response to therapy in patients with long-standing
616 persistent AF or long-standing paroxysmal AF. Despite these inaccuracies, the distinction between paroxysmal
617 and persistent AF has been used in many trials and therefore still forms the basis of some recommendations.

618 There is some evidence suggesting that AF burden may influence stroke risk^{44, 124, 164} and could modify
619 the response to rhythm control therapy.^{76, 165} The evidence for this is weak. Therefore, AF burden should not be
620 a major factor in deciding on the usefulness of an intervention that is deemed suitable for other reasons.

621

622 **Table 5** Patterns of AF

AF pattern	Definition
First diagnosed AF	AF that has not been diagnosed before, irrespective of the duration of the arrhythmia or the presence and severity of AF-related symptoms.
Paroxysmal AF	Self-terminating, in most cases within 48 hours. Some AF paroxysms may continue for up to 7 days. ^a Most AF episodes that are cardioverted within 24-48 hours should be considered paroxysmal. ^a
Persistent AF	AF that lasts longer than 7 days, including episodes that are terminated by cardioversion, either with drugs or by direct current cardioversion, after 7 days or more.
Long-standing persistent AF	Continuous AF lasting for ≥ 1 year when it is decided to adopt a rhythm control strategy.
Permanent AF	AF is accepted by the patient (and physician). Hence, rhythm control

interventions are, by definition, not pursued in patients with permanent AF. Should a rhythm control strategy be adopted, the arrhythmia would be re-classified as 'long-standing persistent AF'.

623 AF = atrial fibrillation.

624 ^aThe distinction between paroxysmal and persistent AF is often not made correctly without access to long-term
625 monitoring.¹⁶³ Hence, this classification alone is often insufficient to select specific therapies. If both persistent
626 and paroxysmal episodes are present, the predominant pattern should guide the classification.
627

628 6.2. Atrial fibrillation types reflecting different causes of the arrhythmia

629 The risk of developing AF is increased in a variety of physiological and disease states, and the historic term
630 'lone AF' is probably misleading and should be avoided.¹⁶⁶ Although the pattern of AF may be the same, the
631 mechanisms underpinning AF vary substantially between patients¹⁶⁷ (Table 6). This suggests that stratifying AF
632 patients by underlying drivers of AF could inform management, for example, considering cardiac and systemic
633 comorbidity (e.g. diabetes and obesity¹⁶⁸), lifestyle factors (e.g. activity level, smoking, alcohol intake^{169, 170}),
634 markers of cardiac structural remodelling (e.g. fibrosis¹⁷¹⁻¹⁷³ or electrocardiographic parameters of AF
635 complexity¹⁷⁴), or genetic background. Table 6 provides such a taxonomy, informed by expert consensus,^{76, 120,}
636 ¹⁷⁵ but without much evidence to underpin its clinical use.¹⁷⁶ Systematic research defining the major drivers of
637 AF is clearly needed to better define different types of AF.¹⁷⁶
638

639 **Table 6 Clinical types of AF (modified from the report on the 4th AFNET/EHRA consensus conference⁷⁶)^a**

AF type	Clinical presentation	Possible pathophysiology
AF secondary to structural heart disease	AF in patients with LV systolic or diastolic dysfunction, long-standing hypertension with LVH, and/or other structural heart diseases. The onset of AF in these patients is a common cause of hospitalization and a predictor of poor outcome	Increased atrial pressure and atrial structural remodelling, together with activation of the sympathetic and renin-angiotensin system
Focal AF	Patients with repetitive atrial runs and frequent, short episodes of paroxysmal AF. Often highly symptomatic, younger patients with distinguishable atrial waves (coarse AF), atrial ectopy, and/or atrial tachycardia deteriorating in AF	Localized triggers, in most cases originating from the pulmonary veins, initiate AF. AF due to one or a few reentrant drivers is also considered to be part of this type of AF
Polygenic AF	AF in carriers of common gene variants that have been associated with early onset AF	Currently under study. The presence of some gene variants may also influence treatment outcomes
Postoperative AF	New onset of AF (usually self-terminating) after major (typically cardiac) surgery in patients who were in sinus rhythm before surgery and had no history of AF	Acute factors: inflammation, atrial oxidative stress, high sympathetic tone, electrolyte changes, and volume overload, possibly interacting with a pre-existing substrate
AF in patients with mitral stenosis or prosthetic heart valves	AF in patients with mitral stenosis, after mitral valve surgery and in some cases other valvular disease	Left atrial pressure (stenosis) and volume (regurgitation) load are the main drivers of atrial enlargement and structural atrial remodelling in these patients
AF in athletes	Usually paroxysmal, related to duration and intensity of training	Increased vagal tone and atrial volume
Monogenic AF	AF in patients with inherited cardiomyopathies, including channelopathies	The arrhythmogenic mechanisms responsible for sudden death are likely to contribute to the occurrence of AF in these patients

640 AF = atrial fibrillation; LV = left ventricular; LVH = left ventricular hypertrophy.

641 ^aIt is recognized that these types of AF will overlap in clinical practice, and that their impact for management
642 needs to be evaluated systematically.
643

644 6.3. Symptom burden in atrial fibrillation

645 Patients with AF have significantly poorer quality of life than healthy controls, experiencing a variety of
 646 symptoms including lethargy, palpitations, dyspnoea, chest tightness, sleeping difficulties, and psychosocial
 647 distress.^{32, 177-180} Improved quality of life has been noted with both pharmacological and interventional
 648 therapies,¹⁸¹⁻¹⁸⁵ but there are limited data to compare the benefit of different treatments.^{32, 186} Assessment of
 649 quality of life is further constrained by a lack of cross-validation of the several AF-specific quality-of-life
 650 tools.¹⁸⁷⁻¹⁹¹ With regard to symptom assessment, the European Heart Rhythm Association (EHRA) suggested
 651 the EHRA symptom scale (*Table 7*) to describe symptom severity in AF patients.¹⁹² A similar scale (the
 652 Canadian Cardiovascular Society Severity of Atrial Fibrillation Scale) is used in Canada.¹⁹³ The EHRA scale
 653 has been used and validated.¹⁹⁴⁻¹⁹⁹ A modification was proposed in 2014, subdividing EHRA class 2 into mild
 654 (2a) or moderate (2b) impact.¹⁹⁹ As symptoms in class 2b ('troubling' symptoms) identified patients with a
 655 health utility benefit of rhythm control in that study, this modification may provide a threshold for potential
 656 treatment decisions, but this remains to be tested. While some AF patients had no or minimal symptoms (25–
 657 40%), many (15–30%) reported severe or disabling symptoms.^{194, 196} The EHRA scale should be used to guide
 658 symptom-orientated treatment decisions and for longitudinal patient profiling.

Table 7 Modified EHRA symptom scale (modified from Wynn et al¹⁹⁹)

Modified EHRA score	Symptoms	Description
1	None	AF does not cause any symptoms
2a	Mild	Normal daily activity not affected by symptoms related to AF ^a
2b	Moderate	Normal daily activity not affected ^a
3	Severe	Normal daily activity affected
4	Disabling	Normal daily activity discontinued

661 AF = atrial fibrillation; EHRA = European Heart Rhythm Association.

662 ^aEHRA class 2a and 2b can be differentiated by evaluating whether patients are functionally affected by their
 663 AF symptoms. AF-related symptoms are most commonly fatigue/tiredness and exertional shortness of breath, or
 664 less frequently palpitations and chest pain.^{42, 194, 200-202}

Recommendation on use of the modified EHRA symptom scale

Recommendation	Class ^a	Level ^b	Refs ^c
Use of the modified EHRA symptom scale is recommended in clinical practice and research studies to quantify AF-related symptoms	I	C	192, 199

667 AF = atrial fibrillation; EHRA = European Heart Rhythm Association.

668 ^aClass of recommendation.

669 ^bLevel of evidence.

670 ^cReference(s) supporting recommendations.

671

7 Detection and management of risk factors and concomitant cardiovascular diseases

672 Many cardiovascular diseases and concomitant conditions increase the risk of developing AF (*Table 8*),
 673 recurrent AF, and AF-associated complications. Identification of such conditions, their prevention and treatment
 674 is an important leverage to prevent AF and its disease burden. Knowledge of these factors and their management
 675 is hence important for optimal management of AF patients.^{203, 204}

Table 8 Cardiovascular and other conditions independently associated with AF

Characteristic/comorbidity	Association with AF
Genetic predisposition (based on multiple common gene variants associated with AF) ⁶⁴	HR range 0.4–3.2

Older age ¹⁹ 50–59 years 60–69 years 70–79 years 80–89 years	HR: 1.00 (reference) 4.98 (95% CI 3.49–7.10) 7.35 (95% CI 5.28–10.2) 9.33 (95% CI 6.68–13.0)
Hypertension (treated) vs. none ¹⁹	HR 1.32 (95% CI 1.08–1.60)
Heart failure vs. none ¹⁹	HR 1.43 (95% CI 0.85–2.40)
Valvular heart disease vs. none ²⁰⁵	RR 2.42 (95% CI 1.62–3.60)
Myocardial infarction vs. none ¹⁹	HR 1.46 (95% CI 1.07–1.98)
Thyroid dysfunction ^{206, 207} hypothyroidism subclinical hyperthyroidism overt hyperthyroidism	(reference: euthyroid) HR 1.23 (95% CI 0.77–1.97) RR 1.31 (95% CI 1.19–1.44) RR 1.42 (95% CI 1.22–1.63)
Obesity ^{19, 208} none (BMI < 25 kg/m ²) overweight (BMI 25–30 kg/m ²) obese (BMI ≥ 31 kg/m ²)	HR: 1.00 (reference) 1.13 (95% CI 0.87–1.46) 1.37 (95% CI 1.05–1.78)
Diabetes mellitus vs. none ¹⁹	HR 1.25 (95% CI 0.98–1.60)
Chronic obstructive pulmonary disease ²⁰⁹ FEV1 ≥ 80% 60–80% < 60%	RR: 1.00 (reference) 1.28 (95% CI 0.79–2.06) 2.53 (95% CI 1.45–4.42)
Obstructive sleep apnoea vs. none ²¹⁰	HR 2.18 (95% CI 1.34–3.54)
Chronic kidney disease ²¹¹ none stage 1 or 2 stage 3 stage 4 or 5	OR: 1.00 (reference) 2.67 (95% CI 2.04–3.48) 1.68 (95% CI 1.26–2.24) 3.52 (95% CI 1.73–7.15)
Smoking ²¹² never former current	HR: 1.00 (reference) 1.32 (95% CI 1.10–1.57) 2.05 (95% CI 1.71–2.47)
Alcohol consumption ²¹³ None 1–6 drinks/week 7–14 drinks/week 15–21 drinks/week > 21 drinks/week	RR: 1.00 (reference) 1.01 (95% CI 0.94–1.09) 1.07 (95% CI 0.98–1.17) 1.14 (95% CI 1.01–1.28) 1.39 (95% CI 1.22–1.58)
Habitual vigorous exercise ²¹⁴ Non-exercisers < 1 day/week 1–2 days/week 3–4 days/week 5–7 days/week	RR: 1.00 (reference) 0.90 (95% CI 0.68–1.20) 1.09 (95% CI 0.95–1.26) 1.04 (95% CI 0.91–1.19) 1.20 (95% CI 1.02–1.41)

680 AF = atrial fibrillation; BMI = body mass index; CI = confidence interval; FEV1 = forced expiratory volume in
681 1 second; HR = hazard ratio; OR = odds ratio; RR = risk ratio
682

683 7.1. Heart failure

684 Heart failure and AF coincide in many patients.^{215–217} They are linked by similar risk factors and share a
685 common pathophysiology.²¹⁸ Heart failure and AF can cause and exacerbate each other through mechanisms
686 such as structural cardiac remodelling, activation of neurohormonal mechanisms, and rate-related impairment of
687 left ventricular (LV) function. Patients with AF and concomitant heart failure, both with preserved ejection
688 fraction (LV ejection fraction [LVEF] ≥ 50%) and reduced ejection fraction (LVEF < 40%),^{219, 220} suffer from a
689 worse prognosis, including increased mortality.^{16, 221} The recent ESC Guidelines on heart failure²²² have also
690 introduced a new category of heart failure with mid-range ejection fraction (HFmrEF; LVEF 40–49%), although
691 data on AF patients in this group are currently limited. Prevention of adverse outcomes and maintenance of a
692 good quality of life are the aims of management in all patients with AF and concomitant heart failure, regardless

693 of LVEF.²²³ The general approach to AF management does not differ between heart failure patients and others,
694 but a few considerations are worthwhile to consider. Of note, the only therapy with proven prognostic value in
695 these patients is anticoagulation, and appropriate OAC should be prescribed in all patients at risk of stroke (see
696 Chapter 8).

697 698 **7.1.1. Patients with atrial fibrillation and heart failure with reduced ejection** 699 **fraction**

700 In addition to OAC, standard heart-failure therapy should be used in patients with heart failure with reduced
701 ejection fraction (HFrEF), as detailed in the ESC Guidelines.²²² This includes angiotensin-converting enzyme
702 (ACE) inhibitors or angiotensin receptor blockers (ARBs), mineralocorticoid antagonists, defibrillators and
703 cardiac resynchronization therapy,²¹⁸ in addition to combined angiotensin receptor neprilysin inhibition (ARNI)
704 in patients able to tolerate an ACE inhibitor or ARB with ongoing symptoms.²²⁴

705 Rate control of AF is discussed in detail in Chapter 9. In brief, only beta-blockers and digoxin are
706 suitable in HFrEF because of the negative inotropic potential of verapamil and diltiazem. Beta-blockers are
707 usually the first-line option in patients with clinically stable HFrEF, although a meta-analysis using individual
708 patient data from randomized controlled trials (RCTs) found no reduction in mortality from beta-blockers versus
709 placebo in those with AF at baseline (HR 0.97, 95% CI 0.83–1.14).²³ Digoxin is commonly prescribed in
710 clinical practice but no head-to-head RCTs in AF patients have been performed. In a meta-analysis of
711 observational studies, digoxin had a neutral effect on mortality in patients with AF and concomitant heart failure
712 (adjusted observational studies HR 0.90, 95% CI 0.70–1.16; propensity-matched observational studies RR 1.08,
713 95% CI 0.93–1.26).²²⁵ Initial and combination rate-control therapy for AF in HFrEF should therefore take
714 account of individual patient characteristics and symptoms; beta-blocker initiation should be delayed in patients
715 with acute decompensated heart failure, and digoxin has more adverse effects in patients with renal impairment
716 (see Chapter 9).

717 Patients with AF and HFrEF who present with severe symptoms may require rhythm control therapy in
718 addition to rate control therapy. For patients who develop HFrEF as a result of rapid AF (tachycardiomyopathy),
719 a rhythm control strategy is preferred, based on several relatively small patient cohorts and trials reporting
720 improved LV function after restoration of sinus rhythm.^{185, 226-228} The diagnosis of tachycardiomyopathy can be
721 challenging, and at times requires restoration of sinus rhythm.²²⁹ Catheter ablation may be a useful method to
722 restore LV function and quality of life in AF patients with HFrEF,^{185, 226-228} but further data are needed. *Figure 4*
723 summarizes the approach to patients with AF and heart failure.

Management of patients presenting acutely with AF and heart failure

Acute management

Chronic management

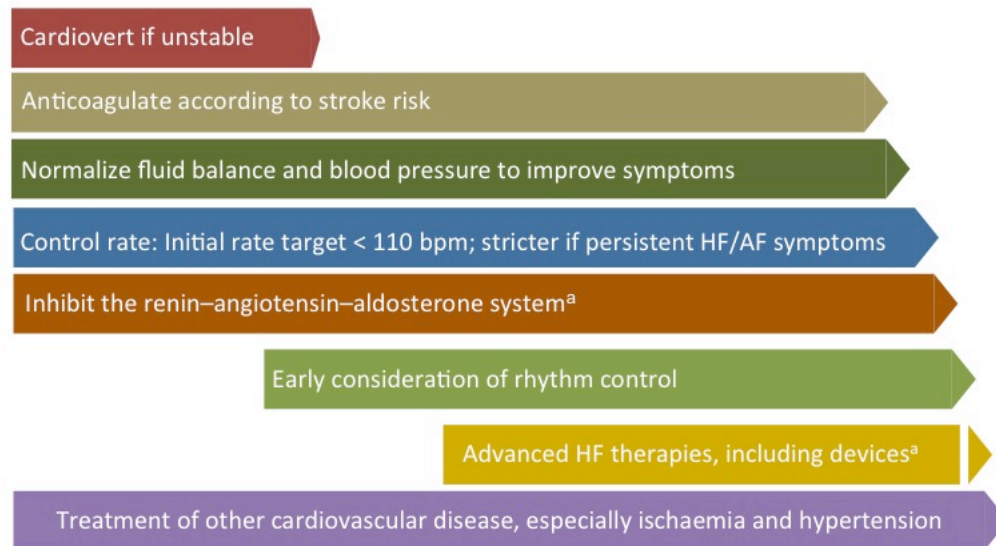


Figure 4 Initial management of newly diagnosed with AF and heart failure. Adapted from Kotecha and Piccini.²¹⁸

ACE = angiotensin-converting enzyme; AF = atrial fibrillation; ARB = angiotensin receptor blocker; ARNI = angiotensin receptor neprilysin inhibition; bpm = beats per minute; HF = heart failure.

^aIn patients with heart failure and reduced ejection fraction; also consider combined ARNI in patients able to tolerate an ACE inhibitor or ARB with ongoing symptoms.

7.1.2. Atrial fibrillation patients with heart failure with preserved ejection fraction

The diagnosis of heart failure with preserved ejection fraction (HFpEF) in patients with AF is problematic because of the difficulty in separating symptoms that are due to HF from those due to AF. Although diagnostic differentiation can be achieved by cardioversion and clinical reassessment, this option is often not appropriate in this group, particularly as a specific therapy that improves prognosis in HFpEF is currently lacking. Echocardiography can support detection of HFpEF in patients with symptomatic AF by providing evidence of relevant structural heart disease (e.g. LV hypertrophy [LVH]) and/or measurement of diastolic dysfunction. Reduced early diastolic myocardial velocity e' by tissue Doppler reflects impaired LV relaxation, while the ratio of E/e' has demonstrated a significant correlation with invasive measurement of LV filling pressures.²³⁰⁻²³⁴ Natriuretic peptide levels are part of the diagnostic assessment of HFpEF,²²² although natriuretic peptide levels are elevated in AF patients and the optimum diagnostic cut-off is still unknown.²³⁵ The management of patients with AF and concomitant HFpEF should focus on control of fluid balance and concomitant conditions such as hypertension and ischaemia.

7.1.3. Atrial fibrillation patients with heart failure with mid-range ejection fraction

HFmrEF is a recently defined entity, describing patients with symptoms and signs of heart failure, LVEF 40–49%, elevated levels of natriuretic peptides, and either LV hypertrophy, left atrial (LA) enlargement, or evidence of diastolic dysfunction.²²² However, diagnosis is more difficult in patients with AF, as natriuretic peptides are elevated in AF and LA dilatation is common, regardless of concomitant heart failure. LVEF is also variable and difficult to assess in AF patients because of AF-induced reduction in systolic LV function and

753 variable cardiac cycle length. Further study of this group is required before particular treatment strategies in AF
754 patients with HFmrEF can be recommended.

755

756 **7.1.4. Prevention of atrial fibrillation in heart failure**

757 Retrospective analyses from large randomized trials have reported a lower incidence of new-onset AF in
758 patients treated with ACE inhibitors/ARBs compared with placebo.²³⁶⁻²³⁸ The reduced incidence of AF with
759 ACE inhibitors/ARBs is less evident in patients with HFpEF²³⁹ and is lost in patients without heart failure.²⁴⁰⁻²⁴²
760 Nephilysin inhibition does not seem to add to this effect.²²⁴ Beta-blocker therapy was associated with a 33%
761 reduction in the adjusted odds of incident AF in HFrEF patients pretreated with ACE inhibitors/ARBs,
762 reinforcing the importance of beta-blocker therapy in HFrEF patients in sinus rhythm.²³ Eplerenone, a
763 mineralocorticoid receptor antagonist, also reduced the risk of new-onset AF in patients with LVEF ≤ 35%,
764 New York Heart Association (NYHA) Class II, and pretreatment with ACE inhibitors/ARBs and beta-
765 blockers.²⁴³

766

767 **7.2. Hypertension**

768 **7.2.1. Treatment of hypertension to prevent incident atrial fibrillation**

769 Inhibition of the renin–angiotensin–aldosterone system can prevent structural remodelling and recurrent AF.^{236,}
770 ²⁴⁴ A recent analysis of the Danish healthcare database with long-term monitoring of the effect of different
771 antihypertensive agents on the occurrence of overt AF suggests a beneficial effect of ACE inhibitors or
772 ARBs.²⁴⁵ Secondary analyses of ACE inhibitors or ARBs in patients with heart failure or LVH show a lower
773 incidence of new-onset AF.^{238, 246}

774

775 **7.2.2. Blood pressure control in patients with atrial fibrillation**

776 Hypertension is a stroke risk factor in AF, and uncontrolled high blood pressure enhances the risk of stroke and
777 bleeding events and may lead to recurrent AF. Good blood-pressure control should therefore form an integral
778 part of the management of AF patients.²⁴⁷ In patients with established AF, but without LV dysfunction or heart
779 failure, ARBs do not prevent recurrent AF better than placebo.^{240, 241} ACE inhibitors or ARBs may reduce
780 recurrent AF after cardioversion when coadministered with antiarrhythmic drug therapy compared with an
781 antiarrhythmic drug alone.^{248, 249} Meta-analyses driven by these studies suggested a lower risk of recurrent
782 AF,^{236-238, 250} but at least one controlled trial failed to demonstrate benefit.^{240, 251}

783

784 **7.3. Valvular heart disease**

785 Valvular heart disease is independently associated with incident AF.²⁵² Approximately 30% of patients with AF
786 have some form of valvular heart disease, often detected only by echocardiography.^{201, 253-255} AF worsens
787 prognosis in patients with severe valvular heart disease,²⁵⁶ including those undergoing surgery or transcatheter
788 interventions for aortic or mitral valve disease.²⁵⁷⁻²⁶² Valvular heart disease can be associated with an increased
789 thromboembolic risk, which probably also adds to the stroke risk in AF patients.²⁶³ Similar to heart failure,
790 valvular disease and AF interact and sustain each other through volume and pressure overload,
791 tachycardiomyopathy, and neurohumoral factors.²⁶⁴⁻²⁷⁰ When valve dysfunction is severe, AF can be regarded as
792 a marker for progressive disease, thus favouring valve repair or replacement.²⁷¹

793

794 Traditionally, patients with AF have been dichotomized into ‘valvular’ and ‘non-valvular’ AF.²⁷²
795 Although slightly different definitions have been used, valvular AF mainly refers to AF patients that have either
796 rheumatic valvular disease (predominantly mitral stenosis) or mechanical heart valves. In fact, while AF implies
797 an incremental risk for thromboembolism in patients with mitral valve stenosis,^{263, 273, 274} there is no clear
798 evidence that other valvular diseases, including mitral regurgitation or aortic valve disease, need to be
799 considered when choosing an anticoagulant or indeed to estimate stroke risk.²⁷⁵ We have therefore decided to
800 replace the historic term ‘non-valvular’ AF with reference to the specific underlying conditions.

801

801 **Recommendations for patients with valvular heart disease and AF**

Recommendations	Class ^a	Level ^b	Refs ^c
Early mitral valve surgery should be considered in severe mitral regurgitation, preserved LV function, and new-onset AF, even in the absence of symptoms, particularly when valve repair is feasible	IIa	C	276

Mitral valvotomy should be considered for asymptomatic patients with severe mitral stenosis and suitable valve anatomy who have new-onset AF	Ila	C	
--	-----	---	--

802 AF = atrial fibrillation; LV = left ventricular.

803 ^aClass of recommendation.

804 ^bLevel of evidence.

805 ^cReference(s) supporting recommendations.

806

807

808 7.4. Diabetes mellitus

809 Diabetes and AF frequently coexist because of associations with other risk factors.²⁷⁷⁻²⁸³ Diabetes is a risk factor
810 for stroke and other complications in AF.²⁸⁴ In patients with AF, a longer duration of diabetes appears to confer
811 a higher risk of thromboembolism, albeit without greater risk of OAC-related bleeding.²⁸⁵ Unfortunately,
812 intensive glycaemic control does not affect the rate of new-onset AF,²⁸⁴ while treatment with metformin seems
813 to be associated with a decreased long-term risk of AF in diabetic patients²⁸⁶ and may even lower long-term
814 stroke risk.¹³ Diabetic retinopathy, a measure of disease severity, does not increase the risk of ocular bleeding in
815 anticoagulated patients.²⁸⁷
816

817 7.5. Obesity and weight loss

818 7.5.1. Obesity as a risk factor

819 Obesity increases the risk for AF (risk ratio 1.5–1.8),²⁸⁸⁻²⁹¹ with a progressive increase according to body mass
820 index.^{288, 290-292} Obese patients may have more LV diastolic dysfunction, increased sympathetic activity and
821 inflammation, and increased fatty infiltration of the atria.²⁹³⁻²⁹⁵ Obesity may also be a risk factor for ischaemic
822 stroke, thromboembolism, and death in AF patients.²⁹²
823

824

824 7.5.2. Weight reduction in obese patients with atrial fibrillation

825 Intensive weight-reduction management in addition to management of other cardiovascular risk factors (in the
826 range of 10–15 kg weight loss achieved) led to fewer AF recurrences and symptoms compared with an approach
827 based on general advice in obese patients with AF.^{203, 204, 296} Improved cardiorespiratory fitness can further
828 decrease AF burden in obese patients with AF.²⁹⁷ Although the findings in these studies have to be confirmed,
829 they underpin the positive effect of weight reduction in obese patients.
830

831

831 7.5.3. Catheter ablation in obese patients

832 Obesity may increase the rate of AF recurrence after catheter ablation,²⁹⁸⁻³⁰¹ with obstructive sleep apnoea as an
833 important potential confounder. Obesity has also been linked to a higher radiation dose and complication rate
834 during AF ablation.^{302, 303} Notably, the symptomatic improvement after catheter ablation of AF in obese patients
835 seems comparable to the improvement in normal-weight patients.²⁹⁸ In view of the potential to reduce AF
836 episodes by weight reduction (see Section 6.5.2.), AF ablation should be offered to obese patients in conjunction
837 with lifestyle modifications that lead to weight reduction.
838

839

839 Recommendation for obese patients with AF

840

841 AF = atrial fibrillation.

Recommendation	Class ^a	Level ^b	Refs ^c
In obese patients with AF, weight loss together with management of other risk factors should be considered to reduce AF burden and symptoms	IIa	B	204, 288, 296

842

843 ^a Class of recommendation

844 ^b Level of evidence

845 ^c Reference(s) supporting recommendation(s)

846

847 7.6. Chronic obstructive pulmonary disease, sleep apnoea, and other respiratory 848 diseases

849 AF has been associated with obstructive sleep apnoea.^{304, 305} Multiple pathophysiological mechanisms can
 850 contribute to AF in obstructive sleep apnoea, including autonomic dysfunction, hypoxia, hypercapnia, and
 851 inflammation.^{96, 304-307} Obstructive sleep apnoea exaggerates intrathoracic pressure changes, which in itself and
 852 via vagal activation can provoke shortening of the atrial action potential and induce AF. Risk factor reduction
 853 and continuous positive airway pressure ventilation can reduce AF recurrence.³⁰⁸⁻³¹² It seems reasonable to
 854 consider obstructive sleep apnoea screening in AF patients with risk factors. Obstructive sleep apnoea treatment
 855 should be optimized to improve AF treatment results in appropriate patients. Servo-controlled pressure support
 856 therapy should not be used in HFrEF patients with predominantly central sleep apnoea (of which 25% had
 857 concomitant AF).³¹³

858 Patients with chronic obstructive pulmonary disease often suffer from atrial tachycardias, which need
 859 to be differentiated from AF by ECG. Agents used to relieve bronchospasm, notably theophyllines and beta-
 860 adrenergic agonists, may precipitate AF and make control of the ventricular response rate difficult. Non-
 861 selective beta-blockers, sotalol, propafenone, and adenosine should be used with caution in patients with
 862 significant bronchospasm, while they can safely be used in patients with chronic obstructive pulmonary disease.
 863 Beta-1 selective blockers (e.g. bisoprolol, metoprolol, and nebivolol), diltiazem, and verapamil are often
 864 tolerated and effective (see Chapter 9).

865 **Recommendations for patients with AF and respiratory diseases**

Recommendations	Class ^a	Level ^b	Refs ^c
Correction of hypoxaemia and acidosis should be considered as initial management for patients who develop AF during an acute pulmonary illness or exacerbation of chronic pulmonary disease	IIa	C	
Interrogation for clinical signs of obstructive sleep apnoea in all AF patients should be considered	IIa	B	304, 305, 314, 315
Obstructive sleep apnoea treatment should be optimized to reduce AF recurrences and improve AF treatment results	IIa	B	307-311

867 AF = atrial fibrillation.

868 ^aClass of recommendation.

869 ^bLevel of evidence.

870 ^cReference(s) supporting recommendations.

871

872 **7.7. Chronic kidney disease**

873 AF is present in 15–20% of patients with CKD.³¹⁶ The definition of CKD in most AF trials is relatively strict.
 874 Although an estimated creatinine clearance (CrCl) rate of < 60 mL/min is indicative of CKD, a number of trials
 875 in AF patients have used CrCl < 50 mL/min to adapt NOAC dosage, usually estimated using the Cockcroft–Gault
 876 formula. CrCl in AF patients can deteriorate over time.³¹⁷ The management of OAC in patients with CKD is
 877 discussed in Section 8.2.4.

878

879 **Recommendations for patients with kidney disease and AF**

880

Recommendations	Class ^a	Level ^b	Refs ^c
The assessment of kidney function by serum creatinine or creatinine clearance is recommended in all AF patients to detect kidney disease and to support correct dosing of AF therapy	I	A	316, 318-321
All AF patients treated with oral anticoagulation should be considered for at least yearly renal function evaluation to detect kidney disease	IIa	B	

881 AF = atrial fibrillation.

882 ^aClass of recommendation.

883 ^bLevel of evidence.

884 ^cReference(s) supporting recommendations.

885

886

8 Integrated management of patients with atrial fibrillation

887

888

889

890

891

892

Most patients access the healthcare system initially through pharmacists, community health workers, or primary care physicians. As AF is often asymptomatic, these healthcare professionals are important stakeholders to enable adequate detection of AF and to ensure consistent management. The initial assessment should be performed at the point of first contact with the healthcare system, and is feasible in most healthcare settings (when an ECG is available). We propose to consider five domains in the initial assessment of patients presenting with newly diagnosed AF (*Figure 5*). These domains are:

893

894

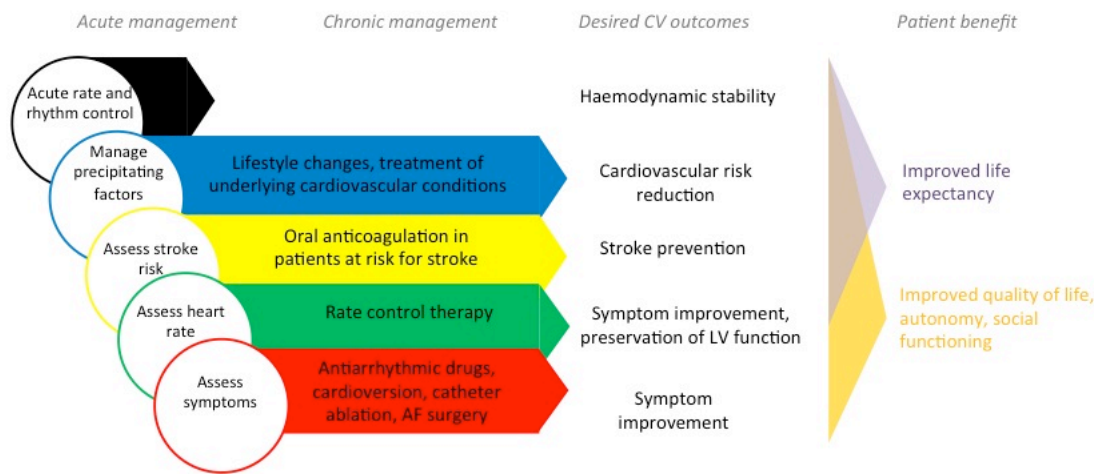
895

896

897

898

1. Haemodynamic instability or limiting, severe symptoms
2. Presence of precipitating factors (e.g. thyrotoxicosis, sepsis, or postoperative AF) and underlying cardiovascular conditions
3. Stroke risk and need for anticoagulation
4. Heart rate and need for rate control
5. Symptom assessment and decision for rhythm control



899

900

901

902

903

904

905

906

907

908

909

910

911

912

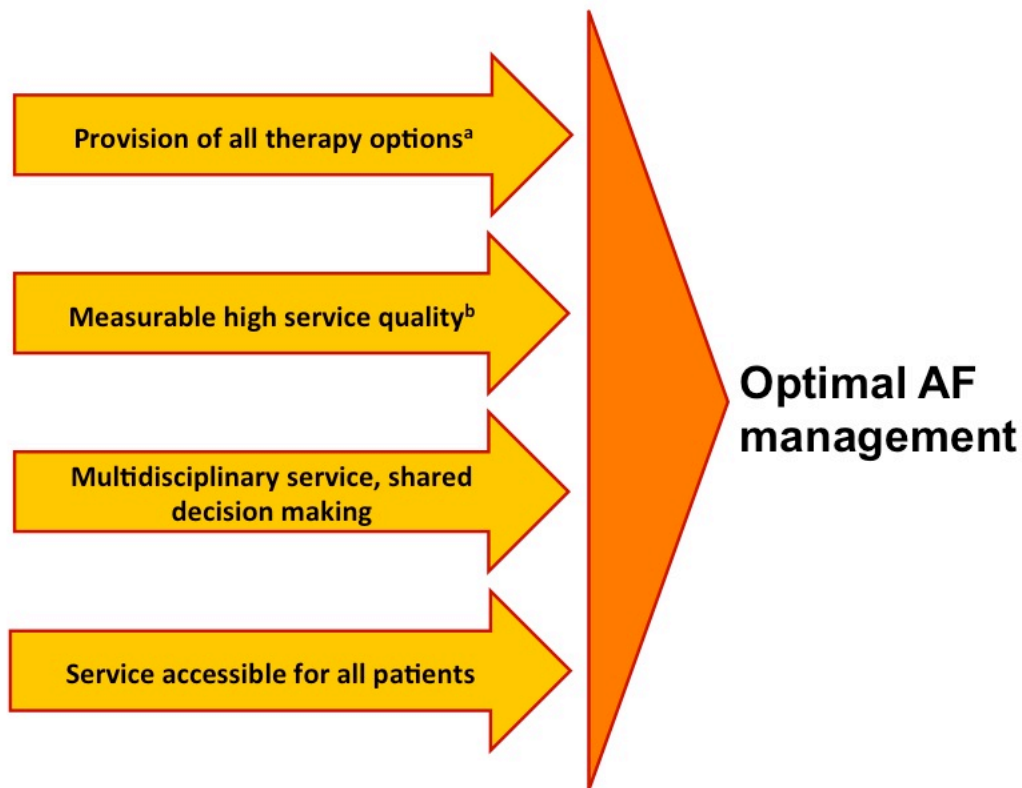
913

914

Figure 5 Acute and chronic management of AF patients, desired cardiovascular outcomes, and patient benefits. Adapted from the report on the 4th AFNET/EHRA consensus conference.⁷⁶ AF = atrial fibrillation; AFNET = German Competence NETwork on Atrial Fibrillation; EHRA = European Heart Rhythm Association.

An integrated, structured approach to AF care, as applied successfully to other domains of medicine,³²²⁻³²⁴ will facilitate consistent, guideline-adherent AF management for all patients³²⁵ (*Figure 6*), with the potential to improve outcomes.^{42, 326, 327} Such approaches are consistent with the Innovative Care for Chronic Conditions Framework proposal put forward by the World Health Organization.³²⁸ Review by an AF service, or at least referral to a cardiologist, will usually be required after the initial assessment to fully evaluate the effect of AF on cardiovascular health.³²⁹ There may also be reasons for early or urgent referral (*Table 9*). Integrated care of all patients with newly diagnosed AF should help to overcome the current shortcomings of AF management, such as underuse of anticoagulation, access to rate and rhythm control therapy, and inconsistent approaches to cardiovascular risk reduction. Integrated AF care requires the cooperation of primary care physicians, cardiologists, cardiac surgeons, AF specialists, stroke specialists, allied health practitioners and patients,

915 encompassing lifestyle interventions, treatment of underlying cardiovascular diseases and AF-specific therapy
916 (Figure 7).



917
918 **Figure 6** Achieving optimal management of AF patients.
919 AF = atrial fibrillation.

920 ^aOn-site or through institutionalized cooperation.

921 ^bSafety outcomes should be collected in published and monitored central databases.

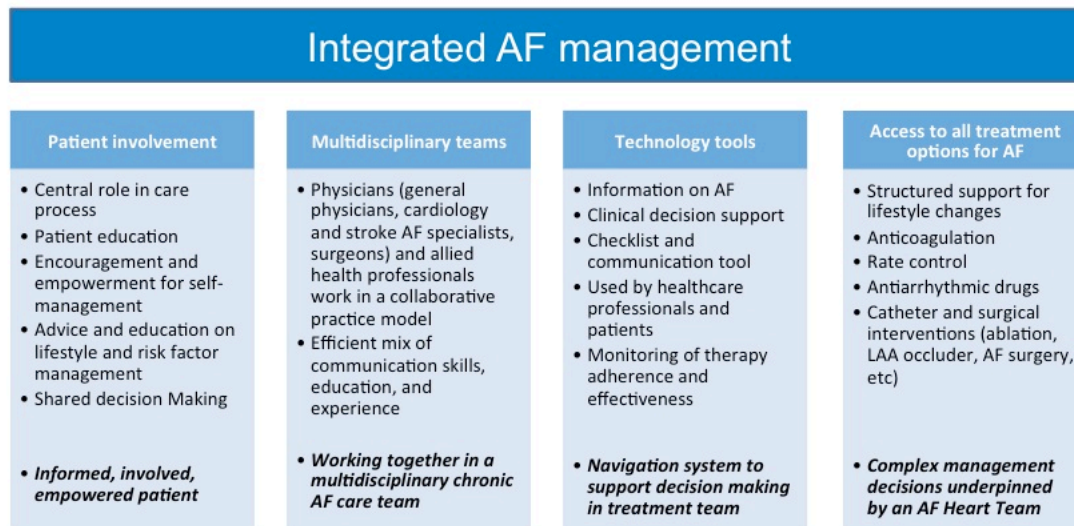


Figure 7 Fundamentals of integrated care in AF patients.
AF = atrial fibrillation; LAA = left atrial appendage.

Table 9 Clinical signs calling for urgent involvement of a specialized AF service.^a

Haemodynamic instability
Uncontrollable rate
Symptomatic bradycardia not amenable to reduced dosing of rate control agents
Severe angina or worsening left ventricular function
Transient ischemic attack or stroke

AF = atrial fibrillation

^aAnticoagulation should be initiated early in all suitable patients and will not routinely require specialist input.

8.1. Evidence supporting integrated atrial fibrillation care

Several structured approaches to AF care have been developed. Some evidence underpins their use, while more research is needed into the best way of delivering integrated AF care. Integrated AF management in an RCT increased the use of evidence-base care and reduced by approximately one-third the composite outcome of cardiovascular hospitalization and cardiovascular death over a mean follow-up of 22 months (14.3% vs. 20.8%, HR 0.65; 95% CI 0.45–0.93; $P = 0.017$) compared with usual care in a large tertiary care centre.³³⁰ Integrated AF management appeared cost-effective in that study.³³¹ However, an Australian RCT showed only a marginal effect on unplanned admissions and death using integrated AF care limited to the initial care period, possibly emphasizing the need for sustained integration of AF care.³³² Two observational studies of integrated AF care found fewer hospitalizations,^{333, 334} one study showed fewer cases of stroke,³³³ and a further non-randomized study identified a trend for a lower rate of the composite outcome of death, cardiovascular hospitalization, and AF-related emergency visits.³³⁵ More research is needed, and integrated AF care is likely to require different designs in different healthcare settings.

8.2. Components of integrated atrial fibrillation care

8.2.1. Patient involvement

946 Patients should have a central role in the care process. As treatment of AF requires patients to change their
 947 lifestyles and adhere to chronic therapy, at times without an immediately tangible benefit, they need to
 948 understand their responsibilities in the care process. Physicians and healthcare professionals are responsible for
 949 providing access to evidence-based therapy, but adherence to therapy is ultimately the responsibility of
 950 informed and autonomous patients, best described as ‘shared accountability’.³³⁶ Hence, information and
 951 education of patients and often of their partners and relatives is indispensable to encourage a self-management
 952 role and to empower patients to participate in shared decision-making,^{326, 328} and to support their understanding
 953 of the disease and the suggested treatments.³³⁷

955 **8.2.2. Multidisciplinary atrial fibrillation teams**

956 Delegation of tasks from specialists to general physicians and from physicians to allied health professionals is a
 957 fundamental concept of integrated care models. A multidisciplinary AF team approach includes an efficient mix
 958 of interpersonal and communication skills, education and expertise in AF management, as well as the use of
 959 dedicated technology. This approach underlines the importance of redesigning daily practice in a way that
 960 encourages non-specialists and allied professionals to have an important role in educating patients and
 961 coordinating care, while the specialist remains medically responsible. Cultural and regional differences will
 962 determine the composition of AF teams.

964 **8.2.3. Role of non-specialists**

965 AF patients often initially present to general practitioners or pharmacists. Some physicians in primary care have
 966 extensive expertise in stroke prevention and initial management of AF patients. Others may seek training to
 967 acquire such knowledge. Other components of AF management (e.g. assessment of concomitant cardiovascular
 968 conditions, antiarrhythmic drug therapy, or interventional treatment) often require specialist input. Integrated
 969 AF care structures should support treatment initiation by non-specialists where appropriate, and provide ready
 970 access to specialist knowledge to optimize AF care.

972 **8.2.4. Technology use to support atrial fibrillation care**

973 Technology, such as decision support software, has the potential to enhance the implementation of evidence-
 974 based care and improve outcomes, when used to enhance expert advice.³³⁸ Electronic tools can also ensure
 975 coherent communication within the AF team. With a view to support the wider use of such technology, this
 976 Task Force is providing tools free of charge, in the form of smartphone apps, to AF healthcare professionals and
 977 to AF patients.

979 **Recommendations for an integrated approach to care**

Recommendations	Class ^a	Level ^b	Refs ^c
An integrated approach with structured organization of care and follow-up should be considered in all patients with AF, aiming to improve guideline adherence and reduce hospitalization and mortality	IIa	B	330-332
Placing patients in a central role in the decision-making should be considered in order to tailor management to patient preferences and improve adherence to chronic therapy	IIa	C	330, 332, 334

980 AF = atrial fibrillation

981 ^aClass of recommendation.

982 ^bLevel of evidence.

983 ^cReference(s) supporting recommendations.

984

985 **8.3. Diagnostic workup of atrial fibrillation patients**

986 AF is often found in patients with other, at times undiagnosed, cardiovascular conditions. Thus, all AF patients
 987 will benefit from a comprehensive cardiovascular assessment.³³⁹

988

989 **8.3.1. Recommended evaluation in all atrial fibrillation patients**

990 A complete medical history should be taken and all patients should undergo clinical evaluation that includes
 991 thorough assessment for concomitant conditions, establishing the AF pattern, estimation of stroke risk and AF-
 992 related symptoms, and assessment of arrhythmia-related complications such as thromboembolism or LV
 993 dysfunction. A 12-lead ECG is recommended to establish a suspected diagnosis of AF, to determine rate in AF,

and to screen for conduction defects, ischaemia, and signs of structural heart disease. Initial blood tests should evaluate thyroid and kidney function as well as serum electrolytes and full blood count. Transthoracic echocardiography is recommended in all AF patients to guide treatment decisions. Transthoracic echocardiography should be used to identify structural disease (e.g. valvular disease) and assess LV size and function (systolic and diastolic), atrial size, and right heart function.^{339, 340} Although biomarkers such as natriuretic peptides are elevated in AF patients, there is insufficient data to suggest that blood-based parameters are independent markers for AF.³⁴¹⁻³⁴³

8.3.2. Additional investigations in selected patients with atrial fibrillation

Ambulatory ECG monitoring in AF patients can assess the adequacy of rate control, relate symptoms with AF recurrences, and detect focal induction of bouts of paroxysmal AF. Transoesophageal echocardiography (TOE) is useful to further assess valvular heart disease and to exclude intracardiac thrombi, especially in the LAA, to facilitate early cardioversion or catheter ablation.³⁴⁴ Patients with symptoms or signs of myocardial ischaemia should undergo coronary angiography or stress testing as appropriate. In patients with AF and signs of cerebral ischaemia or stroke, computed tomography (CT) or magnetic resonance imaging (MRI) of the brain is recommended to detect stroke and support decisions regarding acute management and long-term anticoagulation. Delayed-enhancement MRI of the left atrium using gadolinium contrast,³⁴⁵⁻³⁴⁷ T1 mapping using cardiac MRI,³⁴⁷ and intracardiac echo³⁴⁸ may help to guide treatment decisions in AF, but require external validation in multicentre studies.

8.4. Structured follow-up

Most AF patients need regular follow-up to ensure continued optimal management. Follow-up may be undertaken in primary care, by specially trained nurses, by cardiologists, or by AF specialists.^{325, 330} A specialist should coordinate care and follow-up. Follow-up should ensure implementation of the management plan, continued engagement of the patient, and therapy adaptation where needed.

Recommendations for diagnostic workup of AF patients

Recommendations	Class ^a	Level ^b	Refs ^c
ECG documentation is required to establish the diagnosis of AF	I	B	349
A full cardiovascular evaluation, including an accurate history, careful clinical examination, and assessment of concomitant conditions, is recommended in all AF patients	I	C	
Transthoracic echocardiography is recommended in all AF patients to guide management	I	C	339
Long-term ECG monitoring should be considered in selected patients to assess the adequacy of rate control in symptomatic patients and to relate symptoms with AF episodes	Ila	C	

AF = atrial fibrillation; ECG = electrocardiogram.

^aClass of recommendation.

^bLevel of evidence.

^cReference(s) supporting recommendations.

8.5. Defining goals of atrial fibrillation management

AF management comprises therapies with prognostic impact (anticoagulation and treatment of cardiovascular conditions) and therapies predominantly providing symptomatic benefit (rate control, rhythm control, *Table 10*). Therapies with prognostic benefit need careful explanation to patients when their benefits are not directly felt. Rhythm control therapy can be successful if symptoms are controlled, even when AF recurs. Explaining the expected benefits to each patient at the start of AF management will prevent unfounded expectations and has the potential to optimize quality of life.

Table 10 Goal-based follow-up

Category	Intervention	Follow-up aspects	Performance indicator (examples)
----------	--------------	-------------------	----------------------------------

Prognostic	Comorbidity control (relevant examples given)	Obesity	Weight loss
		Arterial hypertension	Blood pressure control
		Heart failure	Heart failure therapy
		Coronary artery disease	Statin and antiplatelet therapy Revascularization
		Diabetes	Glycaemic control
	Valvular Heart Disease	Valve repair or replacement	
Prognostic	Anticoagulation	Indication (risk profile; timing, e.g. post-cardioversion); Adherence (NOAC or VKA) and INR (if VKA); NOAC dosing (co- medications, age, weight, renal function)	Stroke Bleeding Mortality
Mainly symptomatic Partly prognostic	Rate control	Symptoms Average resting heart rate < 110 bpm	EHRA score Heart failure status LV function Exercise capacity
Symptomatic at present	Rhythm control	Symptoms vs. side-effects Exclusion of proarrhythmia (PR; QRS; QTc interval)	Hospitalization Therapy complications
Relevant for implementation of and adherence to therapy	Patient education and self-care capabilities	Knowledge (about disease; about treatment; about management goals) Capabilities (what to do if...)	Adherence to therapy Directed evaluation, preferably based on systematic checklists
Relevant for chronic care management	Caregiver involvement	Who? (spouse; GP; home nurse; pharmacist) Clearly spelling out participation roles Knowledge and capabilities	Directed evaluation of task performance (e.g. via patient card) Dispensed medication GP log of follow-up visits

1035 bpm = beats per minute; EHRA = European Heart Rhythm Association; GP = general practitioner; INR =
1036 international normalized ratio; LV = left ventricular; NOAC = non-vitamin K antagonist oral anticoagulant;
1037 VKA = vitamin K antagonist.
1038

1039 **9 Stroke prevention therapy in atrial fibrillation patients**

1040 OAC therapy can prevent the majority of ischaemic strokes in AF patients and can prolong life.^{38, 39, 42, 194, 201, 329,}
1041 ³⁵⁰⁻³⁵² It is superior to no treatment or aspirin in patients with different profiles for stroke risk.^{353, 354} The net
1042 clinical benefit is almost universal, with the exception of patients at very low stroke risk, and OAC should
1043 therefore be used in most patients with AF (*Figure 8*). Despite this evidence, underuse or premature termination
1044 of OAC therapy is still common. Bleeding events, both severe and nuisance bleeds, a perceived 'high risk of
1045 bleeding' on anticoagulation, and the efforts required to monitor and dose-adjust VKA therapy are among the
1046 most common reasons for withholding or ending OAC.^{352, 355-359} However, the considerable stroke risk without
1047 OAC often exceeds the bleeding risk on OAC, even in the elderly, in patients with cognitive dysfunction, or in
1048 patients with frequent falls or frailty.^{360, 361} The bleeding risk on aspirin is not different to the bleeding risk on
1049 VKA³⁶² or NOAC therapy,^{354, 363} while VKA and NOACs, but not aspirin, effectively prevent strokes in AF
1050 patients.^{38, 354, 362, 363}
1051

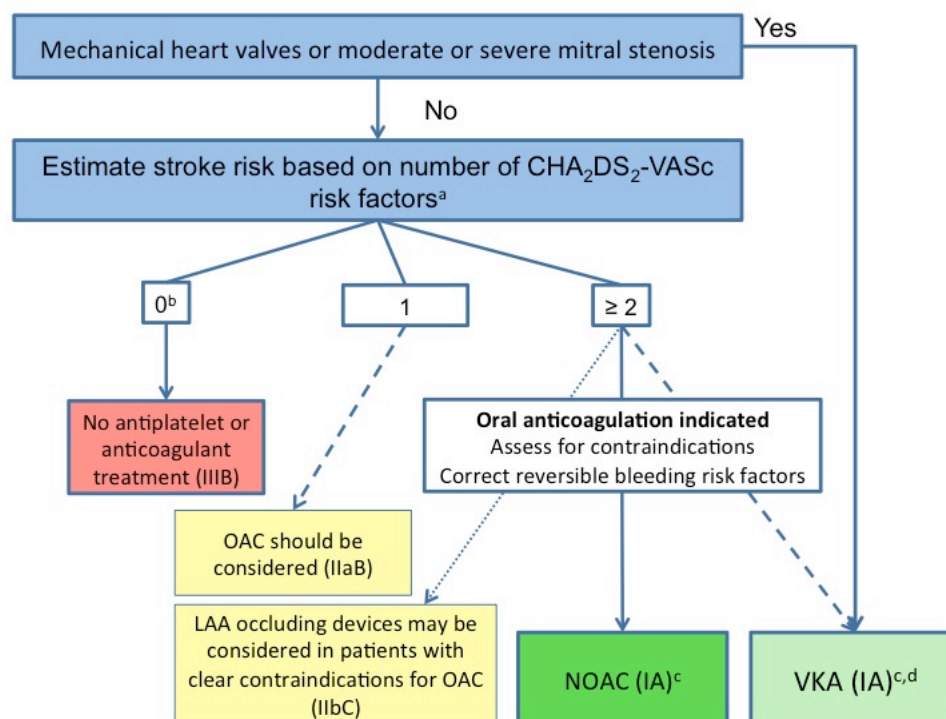


Figure 8 Stroke prevention in AF.

AF = atrial fibrillation; CHA₂DS₂-VASc = Congestive Heart failure, hypertension, Age ≥75 (doubled), Diabetes, Stroke (doubled), Vascular disease, Age 65–74, and Sex (female); LAA = left atrial appendage; NOAC = non-vitamin K antagonist oral anticoagulant; OAC = oral anticoagulation; VKA = vitamin K antagonist.

^aCongestive heart failure, hypertension, age ≥75 years (2 points), diabetes, prior stroke/TIA/embolus (2 points), vascular disease, age 65–74, female sex.

^bIncludes women without other stroke risk factors.

^cIIaB for women with only one additional stroke risk factor,

^dIB for patients with mechanical heart valves or mitral stenosis

9.1. Prediction of stroke and bleeding risk

9.1.1. Clinical risk scores for stroke and systemic embolism

Simple, clinically applicable stroke risk-stratification schemes in AF patients were developed in the late 1990s in small cohort studies and have later been refined and validated in larger populations.³⁶⁴⁻³⁶⁸ The introduction of the CHA₂DS₂-VASc score (Table 11) has clearly simplified the initial decision for OAC in AF patients. Since its first incorporation in the ESC guidelines in 2010,³⁶⁹ it has been widely used.³⁷⁰ We recommend estimating stroke risk in AF patients based on the CHA₂DS₂-VASc score.³⁶⁸ In general, patients without clinical stroke risk factors do not need antithrombotic therapy, while patients with stroke risk factors (i.e. CHA₂DS₂-VASc score of 1 or more for men, and 2 or more for women) are likely to benefit from OAC.

Table 11 Clinical risk factors for stroke, transient ischemic attack, and systemic embolism in the CHA₂DS₂-VASc score.

CHA ₂ DS ₂ -VASc risk factor	Points
Congestive heart failure	+1
Signs/symptoms of heart failure or objective evidence of reduced left-ventricular ejection fraction	

Hypertension Resting blood pressure > 140/90 mmHg on at least two occasions or current antihypertensive treatment	+1
Age 75 years or older	+2
Diabetes mellitus Fasting glucose > 125 mg/dL or treatment with oral hypoglycaemic agent and/or insulin	+1
Previous stroke, transient ischemic attack, or thromboembolism	+2
Vascular disease Previous myocardial infarction, peripheral artery disease, or aortic plaque	+1
Age 65 to 74 years	+1
Sex category (female)	+1

1076 CHA₂DS₂-VASc = Congestive Heart failure, hypertension, Age ≥75 (doubled), Diabetes, Stroke (doubled),
1077 Vascular disease, Age 65–74, and Sex (female).

1078
1079 Other, less established risk factors for stroke include unstable international normalized ratio (INR) and low time
1080 in therapeutic range (TTR) in patients treated with VKAs; previous bleed or anaemia; alcohol excess and other
1081 markers for decreased therapy adherence; CKD; elevated high-sensitivity troponin T; and elevated N-terminal
1082 pro-B-type natriuretic peptide.

1084 9.1.2. Anticoagulation in patients with a CHA₂DS₂-VASc score of 1 in men and 2 1085 in women

1086 Controlled trials studying OAC in AF patients have been enriched for patients at high risk of stroke,^{38, 39, 42, 194,}
1087 ^{201, 329, 351, 352} and hence there is strong evidence that patients with a CHA₂DS₂-VASc risk score of 2 or more in
1088 men, and 3 or more in women benefit from OAC. Fortunately, we now have a growing evidence-base regarding
1089 stroke risk in patients with one clinical risk factor (i.e. CHA₂DS₂-VASc score of 1 for men, and 2 for women),
1090 although this relies largely on observed stroke rates in patients not receiving OAC. In many of these patients,
1091 anticoagulation seems to provide a clinical benefit.³⁷¹⁻³⁷⁵ The rates of stroke and thromboembolism vary
1092 considerably in patients with CHA₂DS₂-VASc scores of 1 or 2 due to differences in outcomes, populations, and
1093 anticoagulation status (*Web Addenda Table 1*).^{371, 376, 377, 1041} OAC should be considered for men with a
1094 CHA₂DS₂-VASc score of 1 and women with a score of 2, balancing the expected stroke reduction, bleeding
1095 risk, and patient preference. Importantly, age (65 years and older) conveys a relatively high and continuously
1096 increasing stroke risk that also potentiates other risk factors (such as heart failure and sex). Hence, an
1097 individualized weighing of risk, as well as patient preferences, should inform the decision to anticoagulate
1098 patients with only one CHA₂DS₂-VASc risk factor, apart from female sex. Female sex does not appear to
1099 increase stroke risk in the absence of other stroke risk factors (*Web Addenda Table 1*).^{378, 379}

1100 Measurement of cardiac troponin (high-sensitivity troponin T or I) and N-terminal pro-B-type
1101 natriuretic peptide may provide additional prognostic information in selected AF patients.³⁸⁰⁻³⁸² Biomarker-
1102 based risk scores may in the future prove helpful to better stratify patients (e.g. those at a truly low risk of
1103 stroke).^{75, 382}

1104 1105 9.1.3. Clinical risk scores for bleeding

1106 Several bleeding risk scores have been developed, mainly in patients on VKAs. These include HAS-BLED
1107 (hypertension, abnormal renal/liver function [1 point each], stroke, bleeding history or predisposition, labile
1108 INR, elderly [>65 years], drugs/alcohol concomitantly [1 point each]), ORBIT (Outcomes Registry for Better
1109 Informed Treatment of Atrial Fibrillation), and more recently, the ABC (age, biomarkers, clinical history)
1110 bleeding score, which also makes use of selected biomarkers.³⁸³⁻³⁸⁵ Stroke and bleeding risk factors overlap
1111 (compare *Table 11* and *Table 12*). For example, older age is one of the most important predictors of both
1112 ischaemic stroke and bleeding in AF patients.^{386, 387} A high bleeding risk score should generally not result in
1113 withholding OAC. Rather, bleeding risk factors should be identified and treatable factors corrected (see Section
1114 8.5). *Table 12* provides details of modifiable bleeding risk factors.

1115
1116 **Table 12** Modifiable and non-modifiable risk factors for bleeding in anticoagulated patients based on
1117 bleeding risk scores.

Modifiable bleeding risk factors
Hypertension (especially when systolic blood pressure is > 160 mmHg) ^{a,b,c}

Labile INR (in patients on vitamin K antagonists) or time in therapeutic range < 60% ^a
Medication predisposing to bleeding, such as antiplatelet drugs and non-steroidal anti-inflammatory drugs ^{a,d}
Excess alcohol (≥ 8 drinks/week) ^{a,b}
Potentially modifiable bleeding risk factors
Anaemia ^{b,c,d}
Impaired renal function ^{a,b,c,d}
Impaired liver function ^{a,b}
Reduced platelet count or function ^b
Non-modifiable bleeding risk factors
Age ^e (> 65 years) ^a (≥ 75 years) ^{b,c,d}
History of major bleeding ^{a,b,c,d}
Previous stroke ^{a,b}
Dialysis-dependent CKD or renal transplant ^{a,c}
Cirrhotic liver disease ^a
Malignancy ^b
Genetic factors ^b
Biomarker-based bleeding risk factors
High-sensitivity troponin T ^e
Growth differentiation factor-15 ^e
Serum creatinine/estimated CrCL ^e

- 1118 ABC = age, biomarkers, clinical history; ATRIA = AnTicoagulation and Risk factors In Atrial fibrillation; CKD
 1119 = chronic kidney disease; CrCl = creatinine clearance; HAS-BLED = hypertension, abnormal renal/liver
 1120 function (1 point each), stroke, bleeding history or predisposition, labile INR, elderly (>65 years), drugs/alcohol
 1121 concomitantly (1 point each); INR = international normalized ratio; ORBIT = Outcomes Registry for Better
 1122 Informed Treatment of Atrial Fibrillation; TTR = time in therapeutic range; VKA = vitamin K antagonist.
 1123 ^aDerived from the HAS-BLED score.³⁸⁴
 1124 ^bDerived from the HEMORR₂HAGES score.³⁸³
 1125 ^cDerived from the ATRIA score.³⁸⁵
 1126 ^dDerived from the ORBIT score.³⁸⁸
 1127 ^eDerived from the ABC bleeding score.³⁸⁷

1128
 1129 **Recommendations for prediction of stroke and bleeding risk**

Recommendations	Class ^a	Level ^b	Refs ^c
The CHA ₂ DS ₂ -VASc score is recommended for stroke risk prediction in patients with AF	I	A	368, 371, 386
Bleeding risk scores should be considered in AF patients on oral anticoagulation to identify modifiable factors for major bleeding	IIa	B	384, 386, 387, 389-392
Biomarkers such as high-sensitivity troponin and N-terminal pro-B-type natriuretic peptide may be considered to further refine stroke and bleeding risk in AF patients	IIb	B	380-382, 387, 393

- 1130 AF = atrial fibrillation; CHA₂DS₂-VASc = Congestive Heart failure, hypertension, Age ≥75 (doubled),
 1131 Diabetes, Stroke (doubled), Vascular disease, Age 65–74, and Sex (female); OAC = oral anticoagulation.
 1132 ^aClass of recommendation.
 1133 ^bLevel of evidence.
 1134 ^cReference(s) supporting recommendations.
 1135

1136 **9.2. Stroke prevention**
 1137 **9.2.1. Vitamin K antagonists**

- 1138 Warfarin and other VKAs were the first anticoagulants used in AF patients. VKA therapy reduces risk of stroke
 1139 by two-thirds and mortality by one-quarter compared with control (aspirin or no therapy).³⁸ VKAs have been
 1140 used in many patients throughout the world with good outcomes,³⁹⁴⁻³⁹⁶ and this is reflected in the warfarin arms
 1141 of the NOAC trials (see Section 8.2.2.). The use of VKAs is limited by the narrow therapeutic interval,
 1142 necessitating frequent monitoring and dose adjustments, but VKAs, when delivered with adequate TTR, are

1143 effective for stroke prevention in AF patients. Clinical parameters can help to identify patients who are likely to
1144 achieve a decent TTR on VKA therapy.³⁹⁷ These have been summarized in the SAME-TT₂R₂ score. Patients who
1145 fare well on this score, when treated with a VKA, have on average a higher TTR than patients who do not fare
1146 well on the score.^{398, 399} VKAs are currently the only treatment with established safety in AF patients with
1147 rheumatic mitral valve disease and/or a mechanical heart valve prosthesis.⁴⁰⁰

1148
1149

9.2.2. Non-vitamin K antagonist oral anticoagulants

1150 NOACs, including the direct thrombin inhibitor dabigatran and the factor Xa inhibitors apixaban, edoxaban, and
1151 rivaroxaban, are suitable alternatives to VKAs for stroke prevention in AF (*Table 13*). Their use in clinical
1152 practice is increasing rapidly.⁴⁰¹ All NOACs have a predictable effect (onset and offset) without need for regular
1153 anticoagulation monitoring. The phase III trials have been conducted with carefully selected doses of the
1154 NOACs, including clear rules for dose reduction that should be followed in clinical practice (*Table 13*).

1155
1156

Apixaban

1157 In the ARISTOTLE (Apixaban for Reduction in Stroke and Other Thromboembolic Events in Atrial
1158 Fibrillation) trial,³¹⁹ apixaban reduced stroke or systemic embolism by 21% compared with warfarin, combined
1159 with a 31% reduction in major bleeding and an 11% reduction in all-cause mortality (all statistically significant).
1160 Rates of haemorrhagic stroke and intracranial haemorrhage, but not of ischaemic stroke, were lower on
1161 apixaban. Rates of gastrointestinal bleeding were similar between the two treatment arms.⁴⁰²

1162 Apixaban is the only NOAC that has been compared with aspirin in AF patients: apixaban significantly
1163 reduced stroke or systemic embolism by 55% compared with aspirin, with no significant difference in rates of
1164 major bleeding or intracranial haemorrhage.^{354, 403}

1165
1166

Dabigatran

1167 In the RE-LY (Randomized Evaluation of Long-Term Anticoagulation Therapy) study,^{318, 404} dabigatran 150 mg
1168 twice daily reduced stroke and systemic embolism by 35% compared with warfarin without a significant
1169 difference in major bleeding events. Dabigatran 110 mg twice daily was non-inferior to warfarin for prevention
1170 of stroke and systemic embolism, with 20% fewer major bleeding events. Both dabigatran doses significantly
1171 reduced haemorrhagic stroke and intracranial haemorrhage. Dabigatran 150 mg twice daily significantly
1172 reduced ischaemic stroke by 24% and vascular mortality by 12%, while gastrointestinal bleeding was
1173 significantly increased by 50%. There was a non-significant numerical increase in the rate of myocardial
1174 infarction with both dabigatran doses,^{318, 404} which has not been replicated in large post-authorization
1175 analyses.³⁹⁶ These data have also replicated the benefit of dabigatran over VKAs found in the RE-LY trial in
1176 patients enriched for the higher dabigatran dose (150 mg twice daily).³⁹⁶

1177
1178

Edoxaban

1179 In the ENGAGE AF-TIMI 48 (Effective Anticoagulation with Factor Xa Next Generation in Atrial Fibrillation–
1180 Thrombolysis in Myocardial Infarction 48) trial,³²¹ edoxaban 60 mg once daily and edoxaban 30 mg once daily
1181 (with dose reductions in certain patients according to *Table 13*), were compared with adjusted-dose warfarin.⁴⁰⁵
1182 Edoxaban 60 mg once daily was non-inferior to warfarin (primary outcome, HR 0.87; 97.5% CI 0.73–1.04; *P* =
1183 0.08). In an on-treatment analysis, edoxaban 60 mg once daily significantly reduced stroke or systemic
1184 embolism by 21% and significantly reduced major bleeding events by 20% compared with warfarin, while
1185 edoxaban 30 mg once daily was non-inferior to warfarin for prevention of stroke and systemic embolism but
1186 significantly reduced major bleeding events by 53%. Cardiovascular death was reduced in patients randomized
1187 to edoxaban 60 mg once daily or edoxaban 30 mg once daily compared with warfarin. Only the higher dose
1188 regimen has been approved for stroke prevention in AF.

1189
1190

Rivaroxaban

1191 In the ROCKET-AF (Rivaroxaban Once Daily Oral Direct Factor Xa Inhibition Compared with Vitamin K
1192 Antagonism for Prevention of Stroke and Embolism Trial in Atrial Fibrillation) trial,³²⁰ patients were
1193 randomized to rivaroxaban 20 mg once daily or VKA, with a dose adjustment to 15 mg daily for those with
1194 estimated CrCl 30–49 mL/min by the Cockcroft–Gault formula. Rivaroxaban was non-inferior to warfarin for the
1195 prevention of stroke and systemic embolism in the intent-to-treat analysis, while the per-protocol on-treatment
1196 analysis achieved statistical superiority with a 21% reduction in stroke or systemic embolism compared with
1197 warfarin. Rivaroxaban did not reduce the rates of mortality, ischaemic stroke, or major bleeding events
1198 compared to VKA. There was an increase in gastrointestinal bleeding events, but a significant reduction in
1199 haemorrhagic stroke and intracranial haemorrhage with rivaroxaban compared with warfarin. Comparable event
1200 rates have been reported in post-authorization analyses, which are part of the post-approval risk-management
1201 process.^{406, 407}

1202 **Table 13** NOACs compared with warfarin in controlled trials

	Dabigatran (RE-LY)	Rivaroxaban (ROCKET-AF)	Apixaban (ARISTOTLE)	Edoxaban (ENGAGE AF-TIMI 48)
Mechanism	Oral direct thrombin inhibitor	Oral direct factor Xa inhibitor	Oral direct factor Xa inhibitor	Oral direct factor Xa inhibitor
Bioavailability, %	6	66 fasting, 80–100 with food	50	62
Time to peak levels, h	3	2–4	3	1–2
Half-life, h	12–17	5–13	9–14	10–14
Excretion	80% renal	66% liver, 33% renal	27% renal	50% renal
Dose	150 mg or 110 mg twice daily	20 mg once daily	5 mg twice daily	60 mg or 30 mg once daily
Dose reduction in selected patients		Rivaroxaban 15 mg once daily if CrCl 30–49 mL/min	Apixaban 2.5 mg twice daily if at least 2 of age ≥ 80 years, body weight ≤ 60 kg or serum creatinine level ≥ 1.5 mg/dL (133 μmol/L)	Edoxaban 60 mg reduced to 30 mg once daily, and edoxaban 30 mg reduced to 15 mg once daily, if any of the following: CrCl 30–50 mL/min, body weight ≤ 60 kg, concomitant use of verapamil or quinidine or dronedarone
Study design	Randomized, open-label	Randomized, double-blind	Randomized, double-blind	Randomized, double-blind
Number of patients	18,113	14,264	18,201	21,105
Follow-up period, years	2	1.9	1.8	2.8
Randomized groups	Dose-adjusted warfarin vs. blinded doses of dabigatran (150 mg twice daily or 110 mg twice daily)	Dose-adjusted warfarin vs. rivaroxaban 20 mg once daily	Dose-adjusted warfarin vs. apixaban 5 mg twice daily	Dose-adjusted warfarin vs. edoxaban (60 mg once daily or 30 mg once daily)
Age, years	Mean ± SD 71.5 ± 8.7	Median 73; IQR 65–78	Median 70; IQR 63–76	Median 72; IQR 64–78
Men, %	63.6	60.3	64.5	61.9
CHADS ₂ score (mean)	2.1	3.5	2.1	2.8

1203

	Warfarin	Dabigatran 150	Dabigatran 110	Warfarin	Rivaroxaban	Warfarin	Apixaban	Warfarin	Edoxaban 60	Edoxaban 30
	<i>n</i> = 6022	<i>n</i> = 6076	<i>n</i> = 6015	<i>n</i> = 7133	<i>n</i> = 7131	<i>n</i> = 9081	<i>n</i> = 9120	<i>n</i> = 7036	<i>n</i> = 7035	<i>n</i> = 7034
	Event rate, %/year	Event rate, %/year (RR vs. warfarin)	Event rate, %/year (RR vs. warfarin)	Event rate, %/year	Event rate, %/year (HR vs. warfarin)	Event rate, %/year	Event rate, %/year (HR vs. warfarin)	Event rate, %/year	Event rate, %/year (HR vs. warfarin)	Event rate, %/year (HR vs. warfarin)
Stroke/systemic embolism	1.72	1.12 (0.65, 0.52–0.81; <i>P</i> for non-inferiority and superiority < 0.001)	1.54 (0.89, 0.73–1.09; <i>P</i> for non-inferiority < 0.001)	2.42	2.12 (0.88, 0.75–1.03; <i>P</i> for non-inferiority < 0.001, <i>P</i> for superiority = 0.12)	1.60	1.27 (0.79, 0.66–0.95; <i>P</i> < 0.001 for non-inferiority, <i>P</i> = 0.01 for superiority)	1.80	1.57 (0.87, 0.73–1.04; <i>P</i> < 0.001 for non-inferiority, <i>P</i> = 0.08 for superiority)	2.04 (1.13, 0.96–1.34; <i>P</i> = 0.005 for non-inferiority, <i>P</i> = 0.10 for superiority)
Ischaemic stroke	1.22	0.93 (0.76, 0.59–0.97; <i>P</i> = 0.03)	1.34 (1.10, 0.88–1.37; <i>P</i> = 0.42)	1.42	1.34 (0.94; 0.75–1.17; <i>P</i> = 0.581)	1.05	0.97 (0.92, 0.74–1.13; <i>P</i> = 0.42)	1.25	1.25 (1.00, 0.83–1.19; <i>P</i> = 0.97)	1.77 (1.41, 1.19–1.67; <i>P</i> < 0.001)
Haemorrhagic stroke	0.38	0.10 (0.26, 0.14–0.49; <i>P</i> < 0.001)	0.12 (0.31, 0.17–0.56; <i>P</i> < 0.001)	0.44	0.26 (0.59; 0.37–0.93; <i>P</i> = 0.024)	0.47	0.24 (0.51, 0.35–0.75; <i>P</i> < 0.001)	0.47	0.26 (0.54, 0.38–0.77; <i>P</i> < 0.001)	0.16 (0.33, 0.22–0.50; <i>P</i> < 0.001)
Major bleeding	3.61	3.40 (0.94, 0.82–1.08; <i>P</i> = 0.41)	2.92 (0.80, 0.70–0.93; <i>P</i> = 0.003)	3.45	3.60 (1.04; 0.90–2.30; <i>P</i> = 0.58)	3.09	2.13 (0.69, 0.60–0.80; <i>P</i> < 0.001)	3.43	2.75 (0.80, 0.71–0.91; <i>P</i> < 0.001)	1.61 (0.47, 0.41–0.55; <i>P</i> < 0.001)
Intracranial bleeding	0.77	0.32 (0.42, 0.29–0.61; <i>P</i> < 0.001)	0.23 (0.29, 0.19–0.45; <i>P</i> < 0.001)	0.74	0.49 (0.67; 0.47–0.93; <i>P</i> = 0.02)	0.80	0.33 (0.42, 0.30–0.58; <i>P</i> < 0.001)	0.85	0.39 (0.47, 0.34–0.63; <i>P</i> < 0.001)	0.26 (0.30, 0.21–0.43; <i>P</i> < 0.001)
Gastrointestinal major bleeding	1.09	1.60 (1.48, 1.19–1.86; <i>P</i> < 0.001)	1.13 (1.04, 0.82–1.33; <i>P</i> = 0.74)	1.24	2.00 (1.61; 1.30–1.99; <i>P</i> < 0.001)	0.86	0.76 (0.89, 0.70–1.15; <i>P</i> = 0.37)	1.23	1.51 (1.23, 1.02–1.50; <i>P</i> = 0.03)	0.82 (0.67, 0.53–0.83; <i>P</i> < 0.001)
Myocardial infarction	0.64	0.81 (1.27, 0.94–1.71; <i>P</i> = 0.12)	0.82 (1.29, 0.96–1.75; <i>P</i> = 0.09)	1.12	0.91 (0.81; 0.63–1.06; <i>P</i> = 0.12)	0.61	0.53 (0.88, 0.66–1.17; <i>P</i> = 0.37)	0.75	0.70 (0.94, 0.74–1.19; <i>P</i> = 0.60)	0.89 (1.19, 0.95–1.49; <i>P</i> = 0.13)
Death from any cause	4.13	3.64 (0.88, 0.77–1.00; <i>P</i> = 0.051)	3.75 (0.91, 0.80–1.03; <i>P</i> = 0.13)	2.21	1.87 (0.85; 0.70–1.02; <i>P</i> = 0.07)	3.94	3.52 (0.89, 0.80–0.99; <i>P</i> = 0.047)	4.35	3.99 (0.92, 0.83–1.01; <i>P</i> = 0.08)	3.80 (0.87, 0.79–0.96; <i>P</i> = 0.006)

1204 AF = atrial fibrillation; CHADS₂ = Cardiac failure, Hypertension, Age, Diabetes, Stroke (Doubled); CrCl = creatinine clearance; HR = hazard ratio; IQR = interquartile range (25th to 75th quartiles); RR = risk ratio; SD = standard deviation.

1206 RRs and HRs compared to warfarin therapy are presented with 95% confidence intervals and *P*-values.

1207

1208 **9.2.3. Non-vitamin K antagonist oral anticoagulants or vitamin K antagonists**

1209 Both VKAs and NOACs are effective for the prevention of stroke in AF. A meta-analysis³⁹ based on the high-
 1210 dose treatment groups of the pivotal studies of warfarin versus NOACs included 42,411 patients receiving a
 1211 NOAC and 29,272 receiving warfarin. NOACs in these dosages significantly reduced stroke or systemic
 1212 embolic events by 19% compared with warfarin (RR 0.81; 95% CI 0.73–0.91; $P < 0.0001$), mainly driven by a
 1213 reduction in haemorrhagic stroke (RR 0.49; 95% CI 0.38–0.64; $P < 0.0001$). Mortality was 10% lower in
 1214 patients randomized to NOAC therapy (RR 0.90; 95% CI 0.85–0.95; $P = 0.0003$) and intracranial haemorrhage
 1215 was halved (RR 0.48; 95% CI 0.39–0.59; $P < 0.0001$), while gastrointestinal bleeding events were more
 1216 frequent (RR 1.25; 95% CI 1.01–1.55; $P = 0.04$).³⁹ The stroke reduction with NOACs was consistent in all
 1217 evaluated subgroups, while there was a suggestion of greater relative reduction in bleeding with NOACs at
 1218 centres with poor INR control (interaction $P = 0.022$). Notably, the substantial reduction in intracranial
 1219 haemorrhage by NOACs compared with warfarin seems unrelated to poor or good INR control.^{408, 409}

1220

1221 **9.2.4. Oral anticoagulation in atrial fibrillation patients with chronic kidney disease**

1222

1223 CKD is associated with stroke and bleeding in large data sets.^{410, 411} Anticoagulation can be safely used in AF
 1224 patients with moderate or moderate-to-severe CKD (glomerular filtration rate [GFR] ≥ 15 mL/min): the SPAF
 1225 (Stroke Prevention in Atrial Fibrillation) III trial randomized 805/1936 participants with stage 3 CKD (estimated
 1226 GFR < 59 mL/min/1.73 m²), and reported good outcomes on warfarin (INR 2–3).⁴¹² This finding is supported by
 1227 a large Swedish database, in which stroke risk was lower in CKD patients with AF treated with warfarin
 1228 (adjusted HR 0.76; 95% CI 0.72–0.80),⁴¹³ while bleeding was also slightly increased, especially during therapy
 1229 initiation.⁴¹⁴ In a meta-analysis of the major NOAC trials, patients with mild or moderate CKD suffered fewer
 1230 strokes, systemic emboli, or major bleeding events on NOACs than on warfarin.⁴¹⁵ Kidney function should be
 1231 regularly monitored in AF patients on OAC to allow dose adaptation for those on NOACs (Table 14) and to
 1232 refine risk estimation.⁴¹⁶

1233

1234 **Table 14 Inclusion criteria, dose adjustments, and outcomes in patients with chronic kidney disease in the**
 1235 **four major randomized trials comparing NOACs with warfarin in patients with AF. Adapted from Hart**
 1236 ***et al.***³¹⁶

	Dabigatran (RE-LY) ^{318, 425}	Rivaroxaban (ROCKET-AF) ^{320, 426}	Apixaban (ARISTOTLE) ^{319, 427}	Edoxaban (ENGAGE AF- TIMI 48) ³²¹
Renal clearance	80%	35%	25%	50%
Number of patients	18,113	14,264	18,201	21,105
Dose	150 mg or 110 mg twice daily	20 mg once daily	5 mg twice daily	60 mg or 30 mg once daily
Exclusion criteria for CKD	CrCl < 30 mL/min	CrCl < 30 mL/min	Serum creatinine > 2.5 mg/dL or CrCl < 25 mL/min	CrCl < 30 mL/min
Dose adjustment with CKD	None	15 mg once daily if CrCl < 30 –49 mL/min	2.5 mg twice daily if serum creatinine ≥ 1.5 mg/dL plus age ≥ 80 years or weight ≤ 60 kg	30 mg or 15 mg once daily if CrCl < 50 mL/min
Per cent of patients with CKD	20% with CrCl 30–49 mL/min	21% with CrCl 30–49 mL/min	15% with CrCl 30–50 mL/dL	19% with CrCl < 50 mL/min
Reduction of stroke and systemic embolism	No interaction with CKD status	No interaction with CKD status	No interaction with CKD status	NA
Reduction of major haemorrhages compared with warfarin	Reduction in major haemorrhage with dabigatran was greater in patients with	Major haemorrhage similar	Reduction in major haemorrhage with apixaban	NA

	estimated GFR > 80 mL/min with either dose			
--	--	--	--	--

1237 AF = atrial fibrillation; CKD = chronic kidney disease; CrCl = creatinine clearance; GFR = glomerular filtration
1238 rate; NA = not available; NOAC = non-vitamin K antagonist oral anticoagulant.

1239

1240 9.2.5. Oral anticoagulation in atrial fibrillation patients on dialysis

1241 Approximately one in eight dialysis patient suffers from AF, with an incidence rate of 2.7/100 patient-years.⁴¹⁷
1242 AF is associated with increased mortality in patients on dialysis.⁴¹⁷ There are no randomized trials assessing
1243 OAC in haemodialysis patients,⁴¹⁸ and no controlled trials of NOACs in patients with severe CKD (CrCl < 25–
1244 30 mL/min).³¹⁸⁻³²¹ Warfarin use was associated either with a neutral or increased risk of stroke in database
1245 analyses of patients on dialysis,⁴¹⁹⁻⁴²¹ including a population-based analysis in Canada (adjusted HR for stroke
1246 1.14; 95% CI 0.78–1.67, adjusted HR for bleeding 1.44; 95% CI 1.13–1.85).⁴²² In contrast, data from Denmark
1247 suggest a benefit of OAC in patients on renal replacement therapy.⁴²³ Hence, controlled studies of
1248 anticoagulants (both VKAs and NOACs) in AF patients on dialysis are needed.⁴²⁴

1249

1250 9.2.6. Patients with atrial fibrillation requiring kidney transplantation

1251 There are no randomized trials assessing OAC in patients after kidney transplantation. The prescription of
1252 NOAC therapy should be guided by the estimated GFR of the transplanted kidney. Potential pharmacokinetic
1253 interactions of OAC with immunosuppressive agents should be considered.

1254

1255

1256 9.2.7. Antiplatelet therapy as an alternative to oral anticoagulants

1257 The evidence supporting antiplatelet monotherapy for stroke prevention in AF is very limited.^{38, 428-430} VKA
1258 therapy prevents stroke, non-central nervous system embolus, myocardial infarction, and vascular death better
1259 than single or dual antiplatelet therapy with aspirin and clopidogrel (annual risk of 5.6% for aspirin and
1260 clopidogrel vs. 3.9% with VKA therapy).⁴³¹ Even greater benefits were seen in VKA-treated patients with a high
1261 TTR.⁴³² Antiplatelet therapy increases bleeding risk, especially dual antiplatelet therapy (2.0% vs. 1.3% with
1262 antiplatelet monotherapy; $P < 0.001$),⁴³³ with bleeding rates that are similar to those on OAC.^{354, 362, 431, 434} Thus,
1263 antiplatelet therapy cannot be recommended for stroke prevention in AF patients.

1264

1265 Recommendations for stroke prevention in patients with AF

Recommendations	Class ^a	Level ^b	Refs ^c
Oral anticoagulation therapy to prevent thromboembolism is recommended for all male AF patients with a CHA₂DS₂-VASc score of 2 or more	I	A	38, 318-321, 354, 404
Oral anticoagulation therapy to prevent thromboembolism is recommended in all female AF patients with a CHA₂DS₂-VASc score of 3 or more	I	A	38, 318-321, 354, 404
Oral anticoagulation therapy to prevent thromboembolism should be considered in male AF patients with a CHA₂DS₂-VASc score of 1, considering individual characteristics and patient preferences	IIa	B	371, 375-377
Oral anticoagulation therapy to prevent thromboembolism should be considered in female AF patients with a CHA₂DS₂-VASc score of 2, considering individual characteristics and patient preferences	IIa	B	371, 376, 377
Vitamin K antagonist therapy (INR 2.0–3.0 or higher) is recommended for stroke prevention in AF patients with moderate-to-severe mitral stenosis or mechanical heart valves	I	B	274, 435-440
When oral anticoagulation is initiated in a patient with AF who is eligible for a NOAC (apixaban, dabigatran, edoxaban, or rivaroxaban), a NOAC is recommended in preference to a Vitamin K antagonist	I	A	39, 318-321, 404
When patients are treated with a vitamin K antagonist, time	I	A	395, 432, 441-444

in therapeutic range (TTR) should be kept as high as possible and closely monitored			
AF patients already on treatment with a vitamin K antagonist may be considered for NOAC treatment if TTR is not well controlled despite good adherence, or if patient preference without contraindication (e.g. prosthetic valve)	IIb	A	39, 318, 319, 404, 408
Combinations of oral anticoagulants and platelet inhibitors increase bleeding risk and should be avoided in AF patients without another indication for platelet inhibition	III (harm)	B	429, 445
In male or female AF patients without additional stroke risk factors, anticoagulant or antiplatelet therapy is not recommended for stroke prevention	III (harm)	B	368, 371, 376, 377
Antiplatelet monotherapy is not recommended for stroke prevention in AF patients, regardless of stroke risk	III (harm)	A	38, 429, 430
NOACs (apixaban, dabigatran, edoxaban, and rivaroxaban) are not recommended in patients with mechanical heart valves (Level of evidence B) or moderate-to-severe mitral stenosis (Level of evidence C)	III (harm)	B/C	318-321, 400, 404

1266 AF = atrial fibrillation; CHA₂DS₂-VASc = Congestive Heart failure, hypertension, Age ≥75 (doubled),
 1267 Diabetes, Stroke (doubled), Vascular disease, Age 65–74, and Sex (female); INR = international normalized
 1268 ratio; NOAC = non-vitamin K antagonist oral anticoagulant; OAC = oral anticoagulation; TTR = time in
 1269 therapeutic range; VKA = vitamin K antagonist.

1270 ^aClass of recommendation.

1271 ^bLevel of evidence.

1272 ^cReference(s) supporting recommendations.

1273

1274 9.3. Left atrial appendage occlusion and exclusion

1275 9.3.1. Left atrial appendage occlusion devices

1276 Interventional LAA occlusion,⁴⁴⁶⁻⁴⁴⁹ and limited experience with percutaneous LAA ligation, has mainly been
 1277 reported in observational studies and registries. Only one device (Watchman®) has been compared with VKA
 1278 therapy in randomized trials (PROTECT AF [Watchman Left Atrial Appendage System for Embolic Protection
 1279 in Patients With AF trial], see *Web Addenda Table 2*; and PREVAIL [Prospective Randomized Evaluation of
 1280 the Watchman LAA Closure Device In Patients with AF Versus Long Term Warfarin Therapy trial]).⁴⁴⁹⁻⁴⁵¹ In
 1281 these data sets, LAA occlusion was non-inferior to VKA treatment for the prevention of stroke in AF patients
 1282 with moderate stroke risk, with a possibility of lower bleeding rates in the patients who continued follow-up.⁴⁵²
 1283 ⁴⁵³ These data were confirmed in a patient-level meta-analysis of the two trials and their associated registries.⁴⁵³
 1284 LAA occlusion may also reduce stroke risk in patients with contraindications to OAC.^{454, 455} The implantation
 1285 procedure can cause serious complications,^{446, 456-458} with high event rates reported in analyses from insurance
 1286 databases and systematic reviews, possibly identifying a certain degree of reporting bias.^{446, 456} A large recent
 1287 European registry reported a high rate of implantation success (98%), with an acceptable procedure-related
 1288 complication rate of 4% at 30 days.⁴⁵⁹ Most patients who historically would be considered unsuitable for OAC
 1289 therapy seem to do relatively well on contemporarily managed OAC.^{396, 407, 460} Adequately powered controlled
 1290 trials are urgently needed to inform the best use of these devices, including LAA occluders in patients who are
 1291 truly unsuitable for OAC or in patients who suffer a stroke on OAC, randomized comparisons of LAA occluders
 1292 with NOACs, and assessment of the minimal antiplatelet therapy acceptable after LAA occlusion.

1293

1294 9.3.2. Surgical left atrial appendage occlusion or exclusion

1295 Surgical LAA occlusion or exclusion concomitant to cardiac surgery has been performed for many decades and
 1296 with various techniques. Multiple observational studies indicate the feasibility and safety of surgical LAA
 1297 occlusion/exclusion, but only limited controlled trial data are available.⁴⁶¹⁻⁴⁶⁴ Residual LAA flow or incomplete
 1298 LAA exclusion can increase stroke risk.⁴⁶⁵ In most studies, LAA occlusion/exclusion was performed during
 1299 other open heart surgery, and more recently in combination with surgical ablation of AF⁴⁶³ or as a stand-alone
 1300 thoracoscopic procedure. One randomized trial evaluating the role of concomitant AF surgery and LAA
 1301 occlusion reported in 2015, without a clear benefit of LAA exclusion for stroke prevention in the subgroup
 1302 undergoing AF surgery.⁴⁶⁶ A large randomized trial is currently underway.⁴⁶⁷

1303

1304 Recommendations for occlusion or exclusion of the LAA

Recommendations	Class ^a	Level ^b	Refs ^c
After surgical occlusion or exclusion of the LAA, it is recommended to continue anticoagulation in at-risk patients with AF for stroke prevention	I	B	461, 462
LAA occlusion may be considered for stroke prevention in patients with AF and contraindications for long-term anticoagulant treatment (e.g. those with a previous life-threatening bleed without a reversible cause)	IIb	B	449, 453, 454
Surgical occlusion or exclusion of the LAA may be considered for stroke prevention in patients with AF undergoing cardiac surgery	IIb	B	463
Surgical occlusion or exclusion of the LAA may be considered for stroke prevention in patients undergoing thoracoscopic ablation surgery	IIb	B	468

1305 AF = atrial fibrillation; LAA = left atrial appendage.

1306 ^aClass of recommendation.

1307 ^bLevel of evidence.

1308 ^cReference(s) supporting recommendations.

1309

1310 9.4. Secondary stroke prevention

1311 The most important risk factors for stroke in patients with AF are advanced age and previous cardioembolic
1312 stroke or TIA,³⁸² emphasizing the need for OAC in these patients. The highest risk of recurrent stroke is in the
1313 early phase after a first stroke or TIA.^{469, 470}

1314

1315 9.4.1. Treatment of acute ischaemic stroke

1316 Systemic thrombolysis with recombinant tissue plasminogen activator (rtPA) is an effective and approved
1317 medical treatment for acute ischaemic stroke in patients presenting within 4.5 hours of symptom onset.⁴⁷¹

1318 Systemic thrombolysis is contraindicated in patients on therapeutic OAC.^{472, 473} Recombinant tissue
1319 plasminogen activator can be given in patients treated with a VKA if the INR is below 1.7,⁴⁷⁴ or in dabigatran-
1320 treated patients with a normal activated partial thromboplastin time and last intake of drug > 48 hours previously
1321 (based on expert consensus).⁴⁷² Whether specific NOAC antidotes⁴⁷⁵ could be used followed by systemic
1322 thrombolysis needs to be investigated. Thrombectomy can be performed in anticoagulated patients with distal
1323 occlusion of the internal carotid artery or middle cerebral artery in a 6-hour window.⁴⁷⁶

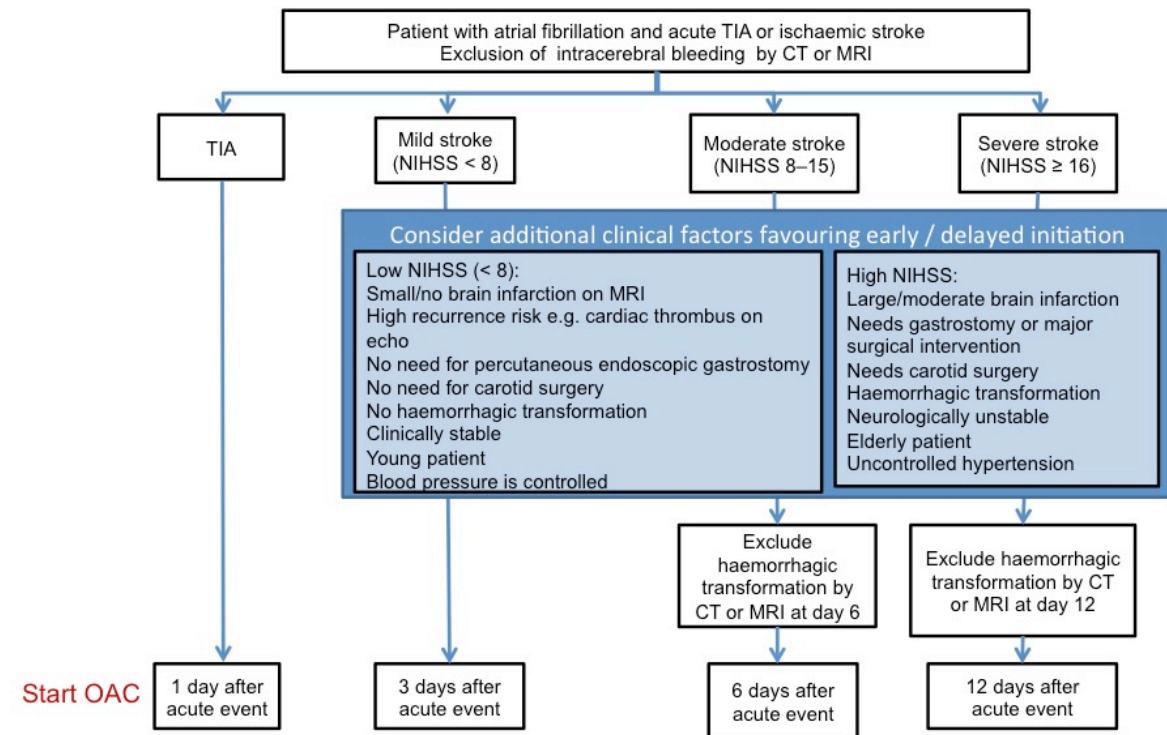
1324

1325 9.4.2. Initiation of anticoagulation after transient ischaemic attack or ischaemic 1326 stroke

1327 Data on the optimal use of anticoagulants (heparin, low-molecular-weight heparin, heparinoid, VKA, NOAC) in
1328 the first days after a stroke are scarce. Parenteral anticoagulants seem to be associated with a non-significant
1329 reduction in recurrent ischaemic stroke when administered 7 to 14 days after the acute stroke (odds ratio [OR]
1330 0.68; 95% CI 0.44–1.06), with a significant increase in symptomatic intracranial bleeding (OR 2.89; 95% CI
1331 1.19–7.01), and a similar rate of death or disability at final follow-up.⁴⁷⁷ It seems likely that the bleeding risk on
1332 parenteral anticoagulation exceeds the stroke prevention benefit in the first days after a large stroke, whereas
1333 patients with a TIA or a small stroke may benefit from early (immediate) initiation or continuation of
1334 anticoagulation. Therefore, we propose to initiate anticoagulation in AF patients between 1 and 12 days after an
1335 ischaemic stroke, depending on its severity (*Figure 9*).⁴⁷⁸ We suggest repeat brain imaging to determine the
1336 optimal initiation of anticoagulation in patients with a large stroke at risk for haemorrhagic transformation.
1337 Long-term OAC with a VKA^{363, 479–481} or NOAC⁴⁸² conveys benefits in AF patients who survived a stroke.
1338 NOACs seem to convey slightly better outcomes, mainly driven by fewer intracranial haemorrhages and
1339 haemorrhagic strokes (OR 0.44, 95% CI 0.32–0.62).⁴⁸² Detailed data for edoxaban have not yet been
1340 published.³²¹ If a patient suffers a stroke or TIA whilst taking an anticoagulant, switching to another
1341 anticoagulant should be considered.

1342

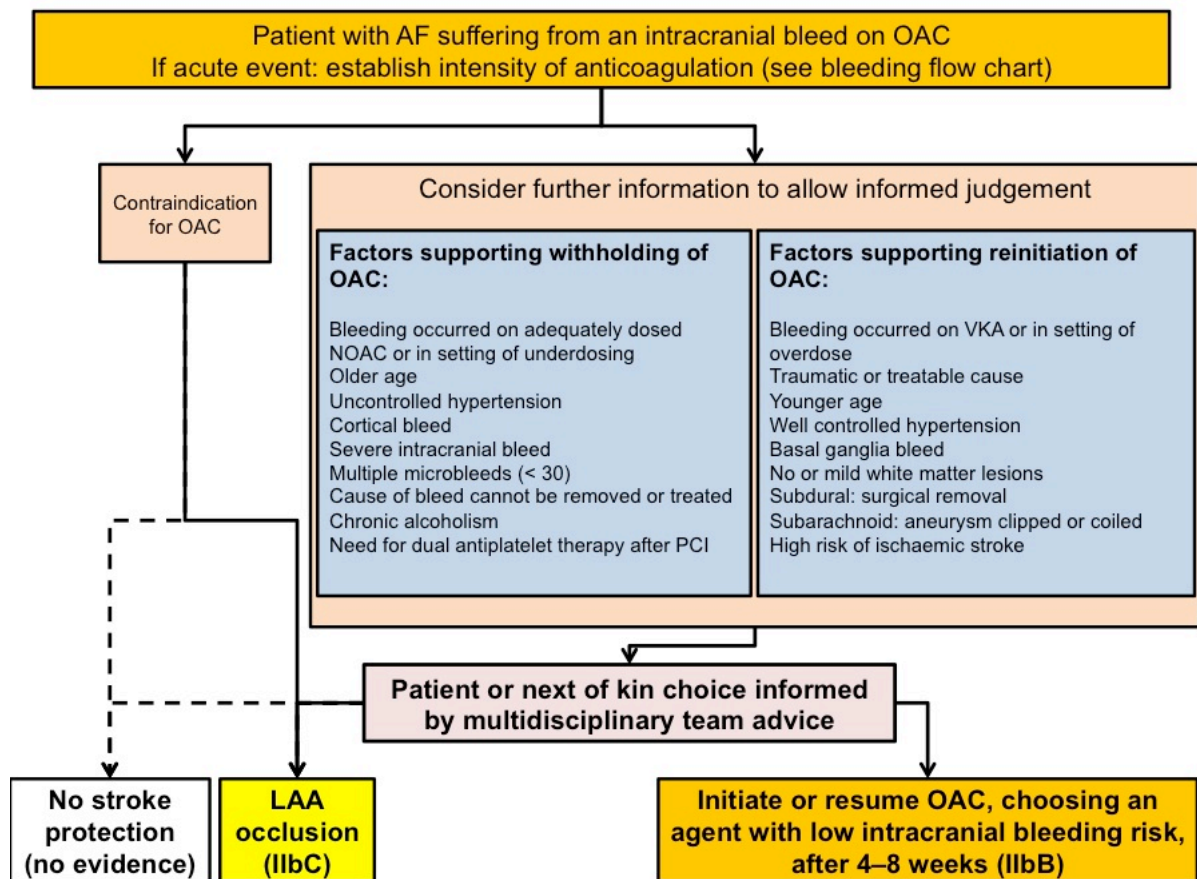
1343 **Figure 9** Initiation or continuation of anticoagulation in AF patients after a stroke or TIA. This approach is
 1344 based on consensus rather than prospective data.



1345 AF = atrial fibrillation; CT = computed tomography; MRI = magnetic resonance imaging; NIHSS = National
 1346 Institutes of Health stroke severity scale (available at [http://www.strokecenter.org/wp-](http://www.strokecenter.org/wp-content/uploads/2011/08/NIH_Stroke_Scale.pdf)
 1347 [content/uploads/2011/08/NIH_Stroke_Scale.pdf](http://www.strokecenter.org/wp-content/uploads/2011/08/NIH_Stroke_Scale.pdf)); OAC = oral anticoagulation; TIA = transient ischaemic
 1348 attack.
 1349

1351 9.4.3. Initiation of anticoagulation after intracranial haemorrhage

1352 No prospective studies have investigated the benefit or risk of the initiation of OAC after intracranial
 1353 haemorrhage,⁴⁸³ and patients with a history of intracranial bleeding were excluded from the randomized trials
 1354 comparing NOACs with VKAs. The available evidence indicates that anticoagulation in patients with AF can be
 1355 reinitiated after 4–8 weeks, especially when the cause of bleeding or the relevant risk factor (e.g. uncontrolled
 1356 hypertension) has been treated, and that such treatment leads to fewer recurrent (ischaemic) strokes and lower
 1357 mortality.^{460, 484} If anticoagulation is resumed, it seems reasonable to consider anticoagulants with a low
 1358 bleeding risk.³⁹ *Figure 10* depicts a consensus opinion on the initiation or resumption of OAC after an
 1359 intracranial haemorrhage. We recommend a multidisciplinary decision with input from stroke
 1360 physicians/neurologists, cardiologists, neuroradiologists, and neurosurgeons.



1361
1362
1363
1364
1365
1366
1367
1368

Recommendations for secondary stroke prevention

Recommendations	Class ^a	Level ^b	Refs ^c
Anticoagulation with heparin or low-molecular-weight heparin immediately after ischaemic stroke is not recommended in AF patients	III (harm)	A	477
In patients who suffer a transient ischemic attack or stroke while on anticoagulation, adherence to therapy should be assessed and optimized	IIa	C	
In patients who suffer a moderate-to-severe ischaemic stroke while on anticoagulation, anticoagulation should be interrupted for 3–12 days based on a multidisciplinary assessment of acute stroke and bleeding risk	IIa	C	
In AF patients who suffer a stroke, aspirin should be considered for prevention of secondary stroke until the initiation or resumption of oral anticoagulation.	IIa	B	485
Systemic thrombolysis with a recombinant tissue plasminogen activator is not recommended if the INR is above 1.7 (or, for patients on dabigatran, if activated partial thromboplastin time is outside the normal range)	III (harm)	C	472, 474
NOACs are recommended in preference to VKAs or aspirin in AF patients with a previous stroke	I	B	363, 482
After TIA or stroke, combination therapy of OAC and an	III (harm)	B	486

antiplatelet is not recommended			
After intracranial haemorrhage, oral anticoagulation in patients with AF may be reinitiated after 4–8 weeks provided the cause of bleeding or the relevant risk factor has been treated or controlled	IIb	B	483, 484, 487

1369

1370

1371 AF = atrial fibrillation; INR = international normalized ratio; NOAC = non-vitamin K antagonist oral
1372 anticoagulant; OAC = oral anticoagulation; TIA = transient ischaemic attack; VKA = vitamin K antagonist.

1373 ^aClass of recommendation.

1374 ^bLevel of evidence.

1375 ^cReference(s) supporting recommendations.

1376

1377 **9.5. Strategies to minimize bleeding on anticoagulant therapy**

1378 In a meta-analysis of 47 studies, the overall incidence of major bleeding with VKAs was 2.1 (range 0.9–3.4) per
1379 100 patient-years in controlled trials and 2.0 (range 0.2–7.6) per 100 patient-years for observational data sets.⁴⁸⁸

1380 Minimizing treatable bleeding risk factors (see *Table 12*) seems paramount to reduce the bleeding rate on
1381 anticoagulants.

1382

1383 **9.5.1. Uncontrolled hypertension**

1384 Uncontrolled blood pressure increases the risk of bleeding on OAC.⁵³ Hence, keeping systolic blood pressure
1385 well controlled is of particular relevance in anticoagulated patients with AF. Treatment according to current
1386 guidelines is recommended in patients with known hypertension.⁴⁸⁹

1387

1388 **9.5.2. Previous bleeding event**

1389 History of bleeding events and the presence of anaemia are important parts of the assessment of all patients
1390 receiving OAC. The majority of bleeding events are gastrointestinal. Compared with warfarin, the risk of
1391 gastrointestinal bleeds was increased for dabigatran 150 mg twice daily,^{396, 490} rivaroxaban 20 mg once daily,⁴⁹¹
1392 and edoxaban 60 mg once daily.³²¹ The risk of gastrointestinal bleeds was comparable to warfarin on dabigatran
1393 110 mg twice daily⁴⁹⁰ and on apixaban 5 mg twice daily.³¹⁹ Recent observational analyses do not replicate these
1394 findings, suggesting a smaller effect.^{396, 492, 493} In patients in whom the source of bleeding has been identified and
1395 corrected, OAC can be reinitiated. This also appears true for patients who have had an intracranial haemorrhage,
1396 once modifiable bleeding risk factors (e.g. uncontrolled hypertension) have been corrected.^{460, 484}

1397

1398 **9.5.3. Labile international normalized ratio and adequate non-vitamin K 1399 antagonist oral anticoagulant dosing**

1400 TTR on VKA therapy is an important predictor of major haemorrhage.^{432, 441, 494} Therefore we recommend
1401 targeting the INR between 2.0 and 3.0 in patients on VKAs, maintaining a high TTR (e.g. $\geq 70\%$ ⁴⁹⁴), and to
1402 consider switching to a NOAC when a high TTR cannot be sustained.⁴⁴⁴ NOAC dosing should follow the dose-
1403 reduction criteria evaluated in the clinical trials, considering renal function, age, and weight. Patient information
1404 and empowerment, best delivered through integrated AF management, seem paramount to achieve this goal.

1405

1406 **9.5.4. Alcohol abuse**

1407 Alcohol excess is a risk factor for bleeding in anticoagulated patients,³⁸⁴ mediated by poor adherence, liver
1408 disease, variceal bleeding, and risk of major trauma. Severe alcohol abuse and binge drinking habits should be
1409 corrected in patients eligible for OAC.

1410

1411 **9.5.5. Falls and dementia**

1412 Falls and dementia are associated with increased mortality in AF patients,⁴⁹⁵ without evidence that these
1413 conditions markedly increase the risk of intracranial haemorrhage.^{495, 496} Hence, anticoagulation should only be
1414 withheld from patients with severe uncontrolled falls (e.g. epilepsy or advanced multisystem atrophy with
1415 backwards falls), or in selected patients with dementia where compliance and adherence cannot be ensured by a
1416 caregiver.

1417

1418 **9.5.6. Genetic testing**

1419 In addition to food and drug interactions, multiple genetic variations affect the metabolism of VKAs.⁴⁹⁷ The
1420 systematic use of genetic information for adjustment of VKA dosage has been evaluated in several controlled
1421 clinical studies.⁴⁹⁸⁻⁵⁰⁰ Genetic testing has little effect on TTR or bleeding risk on warfarin, and is not
1422 recommended for clinical use at present.⁵⁰¹

1423

1424 **9.5.7. Bridging periods off oral anticoagulation**

1425 Most cardiovascular interventions (e.g. percutaneous coronary intervention or pacemaker implantation) can be
1426 performed safely on continued OAC. When interruption of OAC is required, bridging does not seem to be
1427 beneficial, except in patients with mechanical heart valves. In a randomized trial of 1884 patients with AF,
1428 interruption of anticoagulation was non-inferior to heparin administration for the outcome of arterial
1429 thromboembolism (incidence of 0.4% and 0.3%, respectively) and resulted in a lower risk of major bleeding
1430 (1.3% and 3.2%, respectively).⁵⁰² A short interruption or continued OAC should be considered in patients at
1431 highest risk of stroke.

1432

1433 **9.6. Management of bleeding events in anticoagulated patients with atrial fibrillation**

1434 **9.6.1. Management of minor, moderate, and severe bleeding**

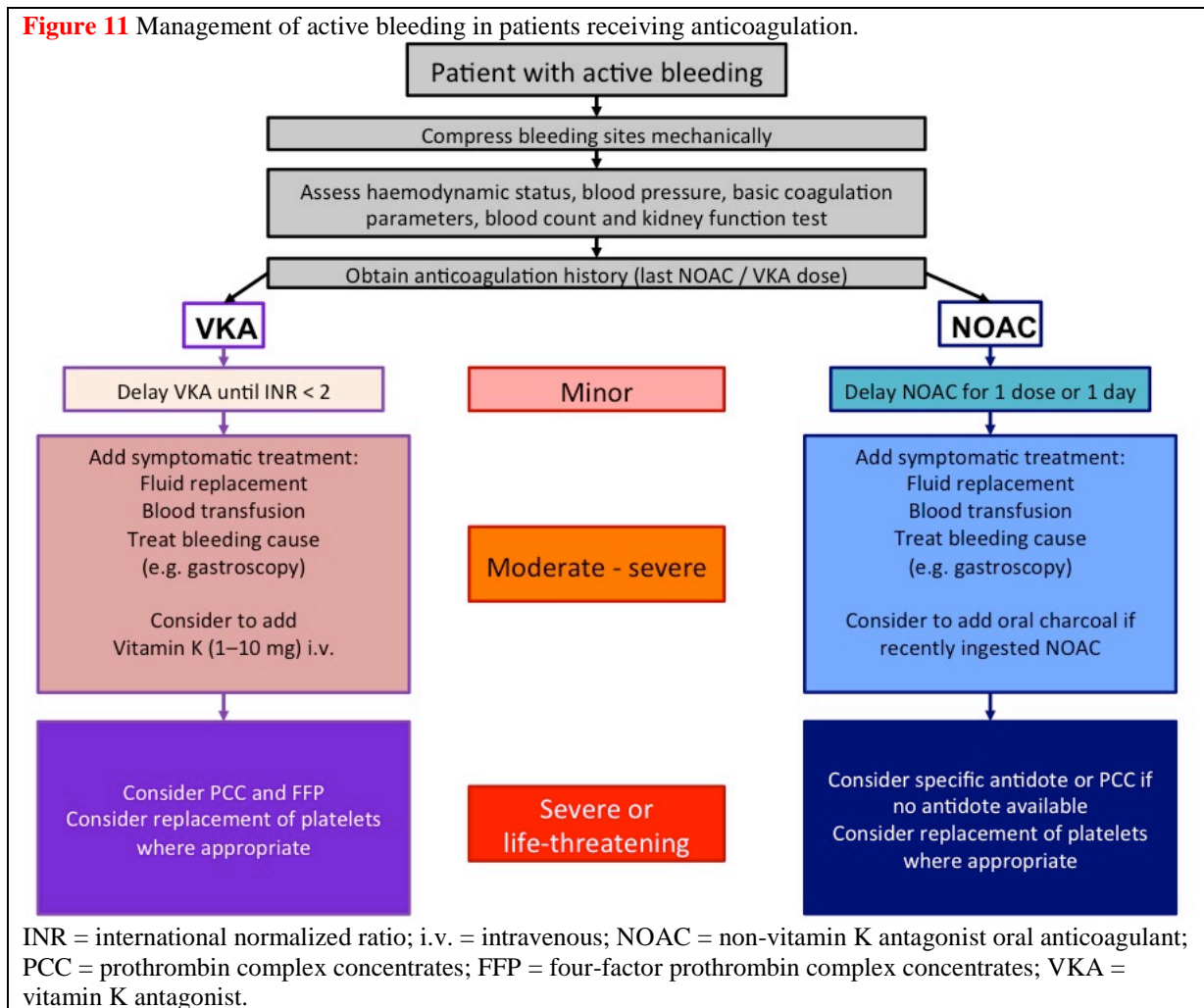
1435 General assessment of an anticoagulated patient with AF experiencing a bleeding event should include
1436 assessment of bleeding site, onset, and severity of the bleeding, the time-point of last intake of OAC and other
1437 antithrombotic drugs, and other factors influencing bleeding risk such as CKD, alcohol abuse, and concurrent
1438 medications. Laboratory tests should include haemoglobin, haematocrit, platelet count, renal function, and for
1439 VKA patients, prothrombin time, activated partial thromboplastin time, and INR. Coagulation tests do not
1440 provide much information in patients on NOACs, except for activated partial thromboplastin time in the case of
1441 dabigatran. More specific coagulation tests do exist, including diluted thrombin time (HEMOCLLOT) for
1442 dabigatran and calibrated quantitative anti-factor Xa assays for factor Xa inhibitors.⁵⁰³ However, these tests are
1443 not always readily available and are often unnecessary for bleeding management.⁵⁰⁴

1444 We propose a simple scheme to manage bleeding events in patients on OAC (*Figure 11*). Minor
1445 bleeding events should be treated with supportive measures such as mechanical compression or minor surgery to
1446 achieve haemostasis. In patients receiving VKAs, the next dose of VKA can be postponed. NOACs have a short
1447 plasma half-life of approximately 12 hours and improved haemostasis is expected within 12–24 hours after a
1448 delayed or omitted dose. Treatment of moderate bleeding events may require blood transfusions and fluid
1449 replacement. Specific diagnostic and treatment interventions directed against the cause of the bleeding (e.g.
1450 gastroscopy) should be performed promptly. If the intake of NOAC was recent (< 2–4 h), charcoal
1451 administration and/or gastric lavage will reduce further exposure. Dialysis clears dabigatran but is not effective
1452 for the other NOACs.

1453 Immediate reversal of the antithrombotic effect is indicated in severe or life-threatening bleeding
1454 events. An agreed, the institutional procedure for the management of life-threatening bleeds should be
1455 documented and accessible at all times to ensure adequate initial management. For VKAs, administration of
1456 fresh frozen plasma restores coagulation more rapidly than vitamin K, and prothrombin complex concentrates
1457 achieve even faster blood coagulation.⁵⁰⁵ Registry data suggest that the combination of plasma and prothrombin
1458 complex concentrates is associated with the lowest case fatality following intracranial haemorrhage on VKA
1459 treatment with an INR ≥ 1.3 .⁵⁰⁶ In a multicentre randomized trial of 188 patients, four-factor prothrombin
1460 complex concentrates achieved more rapid INR reversal and effective haemostasis than plasma in patients
1461 undergoing urgent surgical or invasive procedures.⁵⁰⁷ Administration of prothrombin complex concentrates may
1462 also be considered for severe bleeding on NOAC treatment if specific antidotes are not available.

1463 Several antidotes to NOACs are under development. Idarucizumab (approved in 2015 by the US Food
1464 and Drug Administration and the European Medicines Agency) is a clinically available humanized antibody
1465 fragment that binds dabigatran and rapidly and dose-dependently reverses the effects without over-correction or
1466 thrombin generation.⁴⁷⁵ Andexanet alpha, a modified recombinant human factor Xa that lacks enzymatic
1467 activity, reverses the anticoagulant activity of apixaban and rivaroxaban in healthy probands within minutes
1468 after administration and for the duration of infusion, with a transient increase in markers of coagulation activity
1469 of uncertain clinical relevance.⁵⁰⁸ Another agent under development is ciraparantag (PER977), an antidote
1470 targeted to reverse both direct thrombin and factor Xa inhibitors as well as the indirect inhibitor enoxaparin.⁵⁰⁹
1471 The clinical usefulness of these specific antidotes needs further evaluation.

1472

1473 **Figure 11** Management of active bleeding in patients receiving anticoagulation.

1478

1479 9.6.2. Oral anticoagulation in atrial fibrillation patients at risk of or having a 1480 bleeding event

1481 While anticoagulation therapy should be paused to control active bleeding, absolute contraindications to long-
1482 term OAC after a bleeding episode are rare. When nuisance bleeds are the reason to stop OAC, a change from
1483 one anticoagulant to another seems reasonable. Many causes or triggers of major bleeding events can be treated
1484 and/or eliminated, including uncontrolled hypertension, gastrointestinal ulcers, and intracranial aneurysms.
1485 Reinitiation of anticoagulation after a bleeding event is often clinically justified.^{460, 510} Difficult decisions,
1486 including the discontinuation and recommencement of OAC, should be taken by a multidisciplinary team,
1487 balancing estimated risk of recurrent stroke and bleeding, and considering the bleeding risk of different stroke
1488 prevention therapies. LAA exclusion or occlusion might be an alternative in selected patients.

1489

1490 Recommendations for management of bleeding

Recommendations	Class ^a	Level ^b	Refs ^c
Blood pressure control in anticoagulated patients with hypertension should be considered to reduce the risk of bleeding	IIa	B	511
When dabigatran is used, a reduced dose of dabigatran (110 mg twice daily) may be considered in patients > 75 years to reduce the risk of bleeding	IIb	B	490
In patients at high risk of gastrointestinal bleeding, a VKA or another NOAC should be preferred over dabigatran 150 mg twice daily, rivaroxaban 20 mg once daily, or edoxaban 60 mg once daily	IIa	B	321, 396, 402, 405, 490, 492, 493, 512

Advice and treatment to avoid alcohol excess should be considered in all AF patients considered for OAC	IIa	C	
Genetic testing before the initiation of VKA therapy is not recommended.	III (no benefit)	B	⁴⁹⁷
Reinitiation of OAC after a bleeding event should be considered in all eligible patients by a multidisciplinary AF team, considering different anticoagulants and stroke-prevention interventions, improved management of factors that contributed to bleeding, and stroke risk	IIa	B	⁴⁶⁰
In AF patients with severe active bleeding events, it is recommended to interrupt OAC therapy until the underlying cause is resolved	I	C	

1491 AF = atrial fibrillation; NOAC = non-vitamin K antagonist oral anticoagulant; OAC = oral anticoagulation;

1492 VKA = vitamin K antagonist

1493 ^aClass of recommendation.

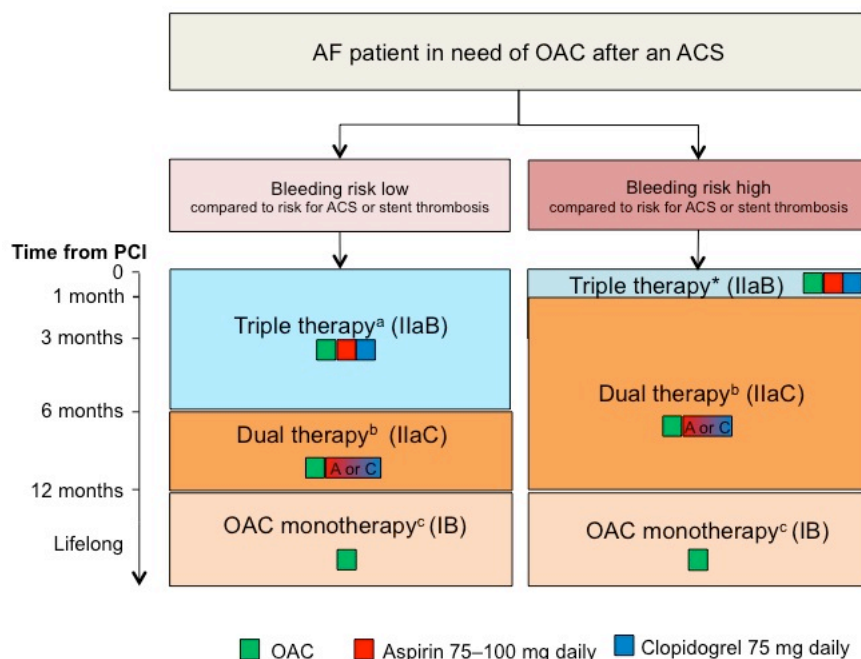
1494 ^bLevel of evidence.

1495 ^cReference(s) supporting recommendations.

1496

1497 **9.7. Combination therapy with oral anticoagulants and antiplatelets**

1498 Approximately 15% of AF patients in contemporary trials⁵¹³ and registries⁵¹⁴⁻⁵¹⁶ have a history of myocardial
 1499 infarction. Between 5% and 15% of AF patients will require stenting at some point in their lives. This scenario
 1500 requires careful consideration of antithrombotic therapy, balancing bleeding risk, stroke risk, and risk of acute
 1501 coronary syndromes (ACS).⁵¹⁶ Co-prescription of OAC with antiplatelet therapy, in particular triple therapy,
 1502 increases the absolute risk of major haemorrhage.^{445, 517, 518} A recent meta-analysis involving 30,866 patients
 1503 with a recent ACS evaluated the effects of adding NOAC therapy to single (4135 patients) or dual (26,731
 1504 patients) antiplatelet therapy.⁵¹⁹ The addition of a NOAC increased the bleeding risk by 79–134%, while
 1505 reducing recurrent ischaemic events only marginally in patients without AF. OAC monotherapy, and not
 1506 combination therapy with antiplatelets, is recommended in AF patients with stable CAD but without an ACS
 1507 and/or coronary intervention in the previous 12 months. In patients treated for ACS and in those receiving a
 1508 coronary stent, short-term triple combination therapy of OAC, clopidogrel, and aspirin seems warranted (*Figure*
 1509 *12*).



1510

1511 **Figure 12** Antithrombotic therapy after an ACS in AF patients requiring anticoagulation.

1512 ACS = acute coronary syndrome; AF = atrial fibrillation; OAC = oral anticoagulation (using vitamin K

1513 antagonists or non-vitamin K antagonist oral anticoagulants); PCI = percutaneous coronary intervention.

1514 ^aDual therapy with OAC and aspirin or clopidogrel may be considered in selected patients, especially those not

1515 receiving a stent or patients at a longer time from the index event.

1516 ^bOAC plus single antiplatelet.1517 ^cDual therapy with OAC and an antiplatelet agent (aspirin or clopidogrel) may be considered in patients at high

1518 risk of coronary events.

1519

1520

1521 9.7.1. Antithrombotic therapy after acute coronary syndromes and percutaneous

1522 coronary intervention in patients requiring oral anticoagulation

1523 The optimal combination antithrombotic therapy or duration of combination therapy for AF patients undergoing

1524 percutaneous coronary intervention is not known, but the continued bleeding risk suggests a short duration.

1525 Expert consensus,⁵²⁰ reviewed and reconsidered by this Task Force, suggests the following principles: AF

1526 patients at risk for stroke, patients with mechanical valves, and patients with recent or recurrent deep vein

1527 thrombosis or pulmonary embolism should continue OAC during and after stenting. In general, a short period of

1528 triple therapy (OAC, aspirin, clopidogrel) is recommended, followed by a period of dual therapy (OAC plus a

1529 single antiplatelet) (*Figure 13*). When a NOAC is used, the consensus recommendation is that the lowest dose

1530 effective for stroke prevention in AF should be considered. Dose reduction beyond the dosing regimens tested in

1531 the phase III trials is not currently recommended, and awaits assessment in ongoing controlled trials. The

1532 combination of aspirin, clopidogrel, and low-dose rivaroxaban (2.5 mg twice daily) is not recommended for

1533 stroke prevention in AF.⁵²¹

1534 The use of prasugrel or ticagrelor as part of triple therapy should be avoided unless there is a clear need

1535 for these agents (e.g. stent thrombosis on aspirin plus clopidogrel), given the lack of evidence and the greater

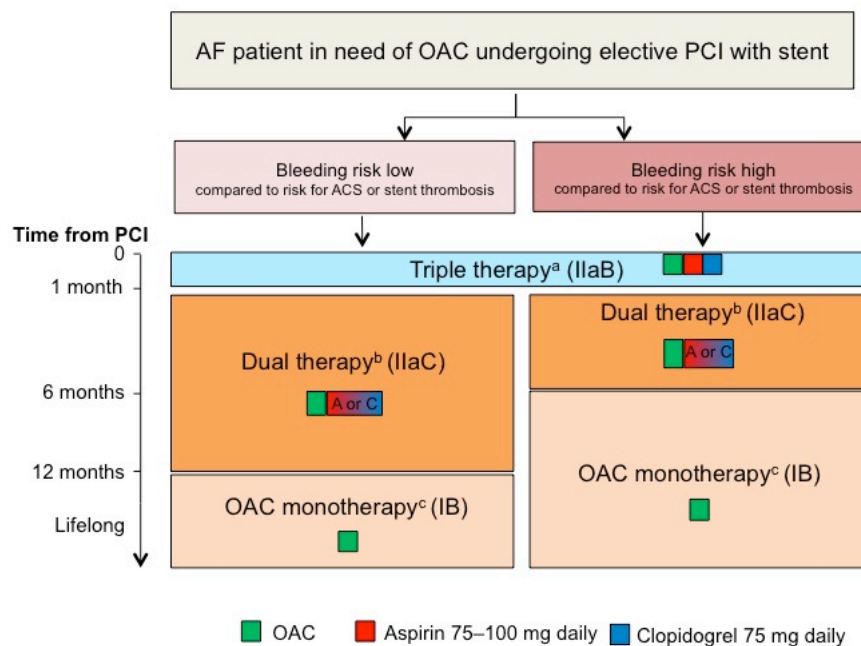
1536 risk of major bleeding compared with clopidogrel.^{522, 523} Ongoing trials will inform about such combination

1537 therapies in the future.

1538 The omission of aspirin while maintaining clopidogrel and OAC has been evaluated in the WOEST

1539 (What is the Optimal antiplatElet and anticoagulant therapy in patients with oral anticoagulation and coronary

1540 StenTing) trial, in which 573 anticoagulated patients undergoing percutaneous coronary intervention (70% with
 1541 AF) were randomized to either dual therapy with OAC and clopidogrel (75 mg once daily) or to triple therapy
 1542 with OAC, clopidogrel, and aspirin.⁵²⁴ Bleeding was lower in the dual versus triple therapy arm, driven by fewer
 1543 minor bleeding events. The rates of myocardial infarction, stroke, target vessel revascularization, and stent
 1544 thrombosis did not differ (albeit with low event numbers), but all-cause mortality was lower in the dual therapy
 1545 group at 1 year (2.5% vs. triple 6.4%). Although the trial was too small to assess ischaemic outcomes, dual
 1546 therapy with OAC and clopidogrel may emerge in the future as an alternative to triple therapy in patients with
 1547 AF and ACS and/or coronary intervention.⁵²⁵



1548
 1549 **Figure 13** Antithrombotic therapy after percutaneous intervention in AF patients requiring anticoagulation.
 1550 ACS = acute coronary syndrome; AF = atrial fibrillation; OAC = oral anticoagulation (using vitamin K
 1551 antagonists or non-vitamin K antagonist oral anticoagulants); PCI = percutaneous coronary intervention.

1552 ^aDual therapy with OAC and aspirin or clopidogrel may be considered in selected patients.

1553 ^bOAC plus single antiplatelet.

1554 ^cDual therapy with OAC and an antiplatelet agent (aspirin or clopidogrel) may be considered in patients at high
 1555 risk of coronary events.

1556

1557 Recommendations for combination therapy with oral anticoagulants and antiplatelets

1558

Recommendations	Class ^a	Level ^b	Refs ^c
After elective coronary stenting for stable coronary artery disease in AF patients at risk of stroke, combination triple therapy with aspirin, clopidogrel and an oral anticoagulant should be considered for 1 month to prevent recurrent coronary and cerebral ischaemic events	IIa	B	522, 524
After an ACS with stent implantation in AF patients at risk of stroke, combination triple therapy with aspirin, clopidogrel, and an oral anticoagulant should be considered for 1–6 months to prevent recurrent coronary and cerebral ischaemic events	IIa	C	520

After an ACS without stent implantation in AF patients at risk of stroke, dual therapy with an oral anticoagulant and aspirin or clopidogrel should be considered for up to 12 months to prevent recurrent coronary and cerebral ischaemic events	IIa	C	
The duration of combination antithrombotic therapy, especially triple therapy, should be kept to a limited period, balancing the estimated risk of recurrent coronary events and bleeding	IIa	B	520
Dual therapy with any oral anticoagulant plus clopidogrel 75 mg/day may be considered as an alternative to initial triple therapy with aspirin in selected patients.	IIb	C	524, 525

1559 ACS = acute coronary syndromes; AF = atrial fibrillation

1560 ^aClass of recommendation.

1561 ^bLevel of evidence.

1562 ^cReference(s) supporting recommendations.

1563

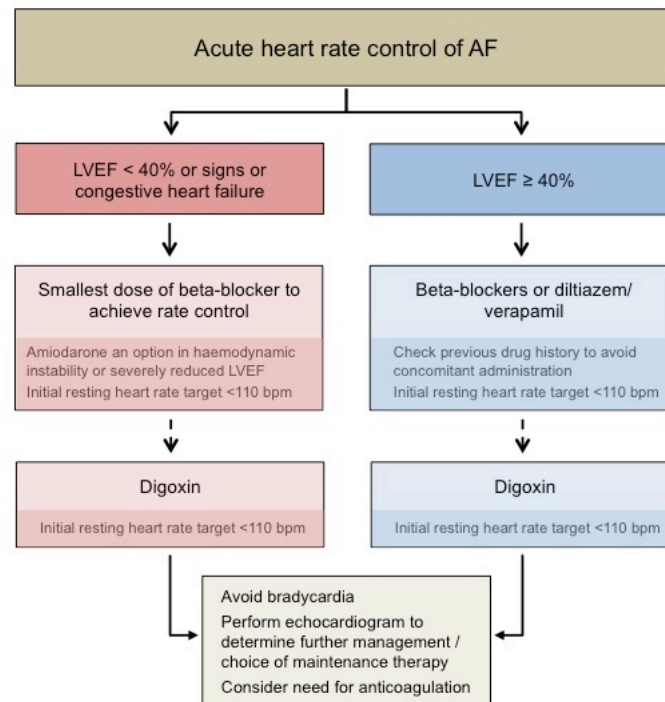
1564 **10 Rate control therapy in AF**

1565 Rate control is an integral part of the management of AF patients, and is often sufficient to improve AF-related
 1566 symptoms. Compared with stroke prevention and rhythm control, very little robust evidence exists to inform the
 1567 best type and intensity of rate control treatment, with the majority of data derived from short-term crossover
 1568 trials and observational studies.^{41, 526-528} Pharmacological rate control can be achieved for acute or long-term rate
 1569 control with beta-blockers, digoxin, the calcium channel blockers diltiazem and verapamil, or combination
 1570 therapy (*Table 15*). A number of antiarrhythmic drugs also have rate-limiting properties (amiodarone,
 1571 dronedarone, sotalol, and to some extent propafenone), but they should only be used in patients needing rhythm
 1572 control therapy (see Chapter 10).

1573

1574 **10.1. Acute rate control**

1575 In the setting of acute new-onset AF, patients are often in need of heart rate control. Physicians should evaluate
 1576 underlying causes of elevated heart rate, such as infection, endocrine imbalance, anaemia, and pulmonary
 1577 embolism. For acute rate control, beta-blockers and diltiazem/verapamil are preferred over digoxin because of
 1578 their rapid onset of action and effectiveness at high sympathetic tone.⁵²⁸⁻⁵³² The choice of drug (*Table 15*) and
 1579 target heart rate will depend on patient characteristics, symptoms, LVEF and haemodynamics, but a lenient
 1580 initial approach to heart rate seems acceptable. Combination therapy may be required (*Figure 14*). In patients
 1581 with evidence of HFrEF, beta-blockers, digitalis (digoxin or digitoxin), or their combination should be used,^{218,}
 1582 ⁵³³ as diltiazem and verapamil can have negative inotropic effects in patients with LVEF < 40%.^{222, 534, 535} In
 1583 critically ill patients and those with severely impaired LV systolic function, intravenous amiodarone can be used
 1584 where excess heart rate is leading to haemodynamic instability.⁵³⁶⁻⁵³⁸ Urgent cardioversion should be considered
 1585 in unstable patients (see Chapter 10.2).



1586
1587
1588
1589
1590

Figure 14 Acute heart rate control of AF.

See Table 15 for medication dosage. Digitoxin is a suitable alternative to digoxin, where available.
AF = atrial fibrillation; bpm = beats per minute; LVEF = left ventricular ejection fraction.

1591 10.2. Long-term pharmacological rate control

1592 10.2.1. Beta-blockers

1593 Beta-adrenoreceptor blocker monotherapy is often the first-line rate-controlling agent,⁵³⁹ largely based on
1594 observations of better acute heart rate control than digoxin. Interestingly, the prognostic benefit of beta-blockers
1595 seen in HFrEF patients with sinus rhythm is lost in those with AF. In an individual patient-level meta-analysis
1596 of RCTs, beta-blockers did not reduce all-cause mortality compared to placebo in those with AF at baseline (HR
1597 0.97; 95% CI 0.83–1.14; $P = 0.73$), whereas there was a clear benefit in patients with sinus rhythm (HR 0.73;
1598 95% CI 0.67–0.80; $P < 0.001$).²³ The study, which included 3066 participants with HFrEF and AF, showed
1599 consistency across all subgroups and outcomes, with no heterogeneity between the 10 RCTs included ($I^2 = 0\%$).
1600 Despite this lack of prognostic benefit in HFrEF, this Task Force still considers beta-blockers as a useful first-
1601 line rate control agent across all AF patients, based on the potential for symptomatic and cardiac function
1602 improvement as a result of rate control, the lack of harm from published studies, and the good tolerability profile
1603 across all ages in sinus rhythm and in AF.^{23, 540}

1604

1605 10.2.2. Non-dihydropyridine calcium channel blockers

1606 Verapamil or diltiazem provides reasonable rate control in AF patients.⁵⁴¹ They should be avoided in patients
1607 with HFrEF because of their negative inotropic effects.^{222, 534, 535} Verapamil or diltiazem can improve
1608 arrhythmia-related symptoms,⁵²⁶ in comparison with beta-blockers, which reduced exercise capacity and
1609 increased B-type natriuretic peptide in one small trial of low-risk patients with preserved LVEF.⁵⁴²

1610

1611 10.2.3. Digitalis

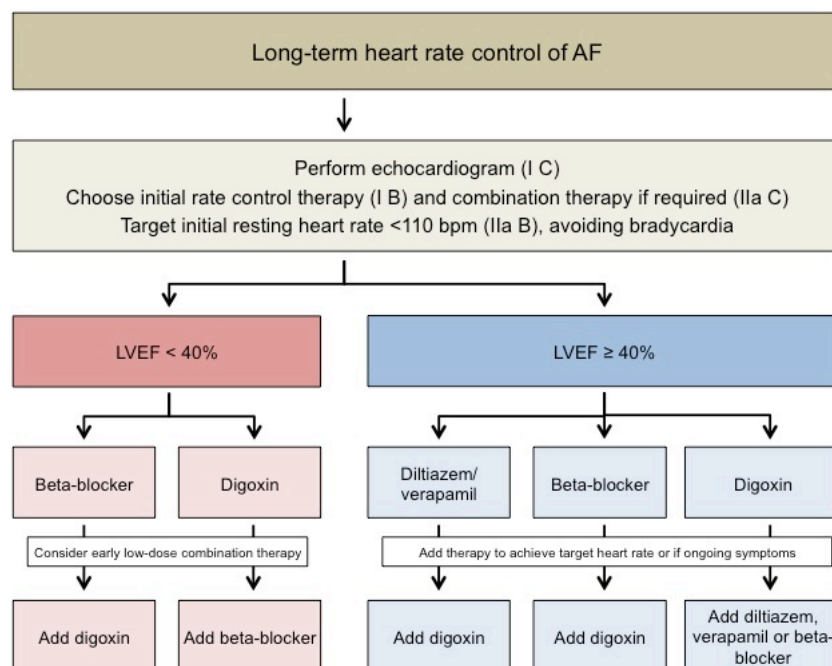
1612 Cardiac glycosides such as digoxin and digitoxin have been in use for over two centuries, although prescriptions
1613 have been declining steadily over the past 15 years.⁵⁴³ In the randomized Digitalis Investigation Group (DIG)
1614 trial, digoxin had no effect on mortality compared to placebo in HFrEF patients in sinus rhythm (RR 0.99; 95%

1615 CI 0.91–1.07), but reduced hospital admissions (RR 0.72; 95% CI 0.66–0.79).^{544, 545} There have been no head-
 1616 to-head RCTs of digoxin in AF patients.⁵⁴⁶ Observational studies have associated digoxin use with excess
 1617 mortality in AF patients,⁵⁴⁷⁻⁵⁴⁹ but this association is likely due to selection and prescription biases rather than
 1618 harm caused by digoxin,⁵⁵⁰⁻⁵⁵³ particularly as digoxin is commonly prescribed to sicker patients.²²⁵ In a
 1619 crossover mechanistic trial of 47 patients with HFrEF and AF, there were no differences in heart rate, blood
 1620 pressure, walking distance, or LVEF between carvedilol and digoxin, although beta-blockers did result in higher
 1621 B-type natriuretic peptide levels, combination carvedilol/digoxin improved LVEF, and digoxin withdrawal
 1622 reduced LVEF.⁵⁵⁴ Comparisons with other rate control therapies are based on small, short-duration studies that
 1623 identify no or marginal differences in exercise capacity, quality of life, or LVEF compared to digoxin.^{526, 554-558}
 1624 Lower doses of digoxin ($\leq 250 \mu\text{g}$ once daily), corresponding to serum digoxin levels of 0.5–0.9 ng/mL, may be
 1625 associated with better prognosis.²²⁵

1627 10.2.4. Amiodarone

1628 Amiodarone can be useful for rate control as a last resort. The wide array of extracardiac adverse effects
 1629 associated with amiodarone renders it a reserve agent in patients whose heart rate cannot be controlled with
 1630 combination therapy (e.g. beta-blocker or verapamil/diltiazem combined with digoxin).

1631
 1632 In summary, there is equipoise for the use of different rate control agents in AF. The choice of beta-blocker,
 1633 diltiazem/verapamil, digoxin, or combination therapy should be made on an individual basis, after consideration
 1634 of patient characteristics and patient preference. All available therapies have the potential for adverse effects and
 1635 patients should initially be treated with a low dose and uptitrated to achieve symptom improvement. In practice,
 1636 achieving a heart rate < 110 bpm will often require combination therapy (*Figure 15*). The benefit of different
 1637 rate control strategies on symptoms, quality of life, and other intermediate outcomes is under investigation.⁵⁵⁹



1638

1639 **Figure 15** Long-term heart rate control of AF.

1640 See *Table 15* for medication dosage. Digitoxin is a suitable alternative to digoxin, where available.

1641 AF = atrial fibrillation; bpm = beats per minute; LVEF = left ventricular ejection fraction.

1642

1643 10.3. Heart rate targets in atrial fibrillation

1644 The optimal heart rate target in AF patients is unclear. The RACE (Rate Control Efficacy in Permanent Atrial
 1645 Fibrillation) II study randomized 614 patients with permanent AF to either a target heart rate < 80 bpm at rest
 1646 and < 110 bpm during moderate exercise, or to a lenient heart rate target of < 110 bpm. There was no difference
 1647 in a composite of clinical events (14.9% in the strict rate control group, 12.9% in the lenient group),⁵⁶⁰ NYHA
 1648 class, or hospitalizations.^{560, 561} Similar results were found in a pooled analysis of the AFFIRM (Atrial
 1649 Fibrillation Follow-up Investigation of Rhythm Management) and RACE trials (1091 participants), albeit with
 1650 smaller heart rate differences and without randomization.⁵⁶² It is worthwhile to note that many ‘adequately rate-
 1651 controlled’ patients (resting heart rate 60–100 bpm) are severely symptomatic, calling for additional
 1652 management.¹⁹⁴ Nonetheless, lenient rate control is an acceptable initial approach, regardless of heart failure
 1653 status, unless symptoms call for stricter rate control.
 1654

1655 10.4. Atrioventricular node ablation and pacing

1656 Ablation of the atrioventricular node/His bundle and implantation of a VVI pacemaker can control ventricular
 1657 rate when medications fail to control rate and symptoms. It is a relatively simple procedure with a low
 1658 complication rate and low long-term mortality risk,^{563, 564} especially when the pacemaker is implanted a few
 1659 weeks before the AV nodal ablation and the initial pacing rate after ablation is set at 70–90 bpm.^{565, 566} The
 1660 procedure does not worsen LV function⁵⁶⁷ and may even improve LVEF in selected patients.⁵⁶⁸⁻⁵⁷⁰ In some
 1661 patients in heart failure treated with biventricular pacing (cardiac resynchronization therapy), AF can
 1662 terminate,⁵⁷¹ although such a ‘rhythm control’ effect of cardiac resynchronization therapy is likely to be small
 1663 and clearly needs confirmation.⁵⁷² AV nodal ablation renders patients pacemaker-dependent for the rest of their
 1664 lives, limiting AV nodal ablation and pacing to patients whose symptoms cannot be managed by rate controlling
 1665 medication or by reasonable rhythm control interventions. The choice of pacing therapy (right ventricular or
 1666 biventricular pacing with or without an implantable defibrillator) will depend on individual patient
 1667 characteristics, including LVEF.^{573, 574}
 1668

1669 Recommendations for rate control

Recommendations	Class ^a	Level ^b	Refs ^c
Beta-blocker, digoxin, diltiazem, or verapamil are recommended to control heart rate in AF patients with LVEF ≥ 40%	I	B	225, 526, 528, 531, 532, 541, 555, 575
Beta-blocker and/or digoxin are recommended to control heart rate in AF patients with LVEF < 40%	I	B	23, 225, 526, 533, 554, 575, 576
Combination therapy comprising different rate controlling agents should be considered if a single agent does not achieve the necessary heart rate target	IIa	C	23, 554, 577
In cases of haemodynamic instability or severe depression in LVEF, amiodarone may be considered for acute control of heart rate	IIb	B	536-538
In patients with permanent AF (i.e. where no attempt to restore sinus rhythm is planned), antiarrhythmic drugs should not routinely be used for rate control	III (harm)	A	41, 578, 579
A resting heart rate of < 110 bpm (i.e. lenient rate control) should be considered as the initial heart rate target for rate control therapy	IIa	B	560
Rhythm rather than rate control strategies should be considered as the preferred management in pre-excited AF and AF during pregnancy	IIa	C	
Atrioventricular node ablation should be considered to control heart rate in patients unresponsive or intolerant to intensive rate and rhythm control therapy, accepting that these patients will become pacemaker dependent	IIa	B	184, 564, 569

1670 AF = atrial fibrillation; bpm = beats per minute; LVEF = left ventricular ejection fraction.

1671 Digitoxin is a suitable alternative to digoxin, where available. In patients with heart failure with reduced ejection
 1672 fraction (LVEF < 40%), recommended beta-blockers are bisoprolol, carvedilol, long-acting metoprolol, and
 1673 nebivolol.

1674 ^aClass of recommendation.

1675 ^b Level of evidence.1676 ^c Reference(s) supporting recommendations.

1677

1678 **Table 15 Rate control therapy in AF**

Therapy	Acute intravenous rate control	Long-term oral rate control	Side-effect profile	Comments
Beta-blockers^a				
Bisoprolol	Not available	1.25–20 mg once daily or split	Most common reported adverse symptoms are lethargy, headache, peripheral oedema, upper respiratory tract symptoms, gastrointestinal upset, and dizziness. Adverse effects include bradycardia, atrioventricular block, and hypotension	Bronchospasm is rare – in cases of asthma, recommend beta-1 selective agents (avoid carvedilol). Contraindicated in acute cardiac failure and a history of severe bronchospasm
Carvedilol	Not available	3.125–50 mg twice daily		
Metoprolol	2.5–10 mg intravenous bolus (repeated as required)	100–200 mg total daily dose (according to preparation)		
Nebivolol	N/A	2.5–10 mg once daily or split		
Esmolol	0.5 mg intravenous bolus over 1 min; then 0.05–0.25 mcg/kg/min			
Calcium-channel blockers				
Diltiazem	15–25 mg intravenous bolus (repeated as required)	60 mg three times daily up to 360 mg total daily dose (120–360 mg once daily modified release)	Most common reported adverse symptoms are dizziness, malaise, lethargy, headache, hot flushes, gastrointestinal upset, and oedema. Adverse effects include bradycardia, atrioventricular block, and hypotension (prolonged hypotension possible with verapamil)	Use with caution in combination with beta-blockers. Reduce dose with hepatic impairment and start with smaller dose in renal impairment. Contraindicated in LV failure with pulmonary congestion or LVEF < 40%
Verapamil	2.5–10 mg intravenous bolus (repeated as required)	40–120 mg three times daily (120–480 mg once daily modified release)		
Cardiac glycosides				
Digoxin	0.5 mg intravenous bolus (0.75–1.5 mg over 24 h in divided doses)	0.0625–0.25 mg daily dose	Most common reported adverse symptoms are gastrointestinal upset, dizziness, blurred vision, headache, and rash. In toxic states (serum levels > 2 ng/mL), digoxin is proarrhythmic and can aggravate heart failure, particularly with coexistent hypokalaemia	High plasma levels associated with increased risk of death. Check renal function before starting and adapt dose in patients with CKD. Contraindicated in accessory conducting pathways, ventricular tachycardia, and hypertrophic cardiomyopathy with outflow tract obstruction
Digitoxin	0.4–0.6 mg intravenous bolus	0.05–0.3 mg daily dose		
Specific indications				
Amiodarone	300 mg	200 mg daily	Hypotension,	Suggested as

intravenously diluted in 250 mL 5% dextrose over 30–60 min (preferably via central venous cannula)^b

bradycardia, nausea, QT prolongation, pulmonary toxicity, skin discolouration, thyroid dysfunction, corneal deposits, and cutaneous reaction with extravasation

adjunctive therapy in patients where heart rate control cannot be achieved using combination therapy

1679 AF = atrial fibrillation; CKD = chronic kidney disease; LV = left ventricular; LVEF = left ventricular ejection
1680 fraction.

1681 ^aA number of other beta-blockers are also available, but are not recommended as specific rate control therapy in
1682 AF. These include atenolol (25–100 mg once daily with a short biological half-life), propranolol (non-selective,
1683 1 mg over 1 min and repeat up to 3 mg at 2-min intervals [acute] or 10–40 mg three times daily [long-term]), or
1684 labetalol (non-selective, 1–2 mg/min [acute]).

1685 ^bIf ongoing requirement for amiodarone, follow with 900 mg intravenous over 24 hours diluted in 500–1000 mL
1686 via a central venous cannula.

1687

1688 **11 Rhythm control therapy in atrial fibrillation**

1689 Restoring and maintaining sinus rhythm is an integral part of AF management. Antiarrhythmic drugs
1690 approximately double the rate of sinus rhythm compared with placebo.⁵⁸⁰⁻⁵⁸⁴ Catheter ablation or combination
1691 therapy is often effective when antiarrhythmic drugs fail.^{226, 585-587} Although many clinicians believe that
1692 maintaining sinus rhythm can improve outcomes in AF patients,⁵⁸⁸ all trials that have compared rhythm control
1693 to rate control (with appropriate anticoagulation) therapy have resulted in neutral outcomes.^{41, 578, 579, 582, 589-593}

1694 Whether modern rhythm control management involving catheter ablation, combination therapy, and early
1695 therapy leads to a reduction in major cardiovascular events (e.g. stroke and cardiovascular death) is currently
1696 under investigation (e.g. in the EAST [Early treatment of Atrial fibrillation for Stroke prevention Trial] –
1697 AFNET 4⁴⁰ and CABANA [Catheter Ablation vs Anti-arrhythmic Drug Therapy for Atrial Fibrillation Trial]⁵⁹⁴
1698 trials). For now, rhythm control therapy is indicated to improve symptoms in AF patients who remain
1699 symptomatic on adequate rate control therapy.

1700

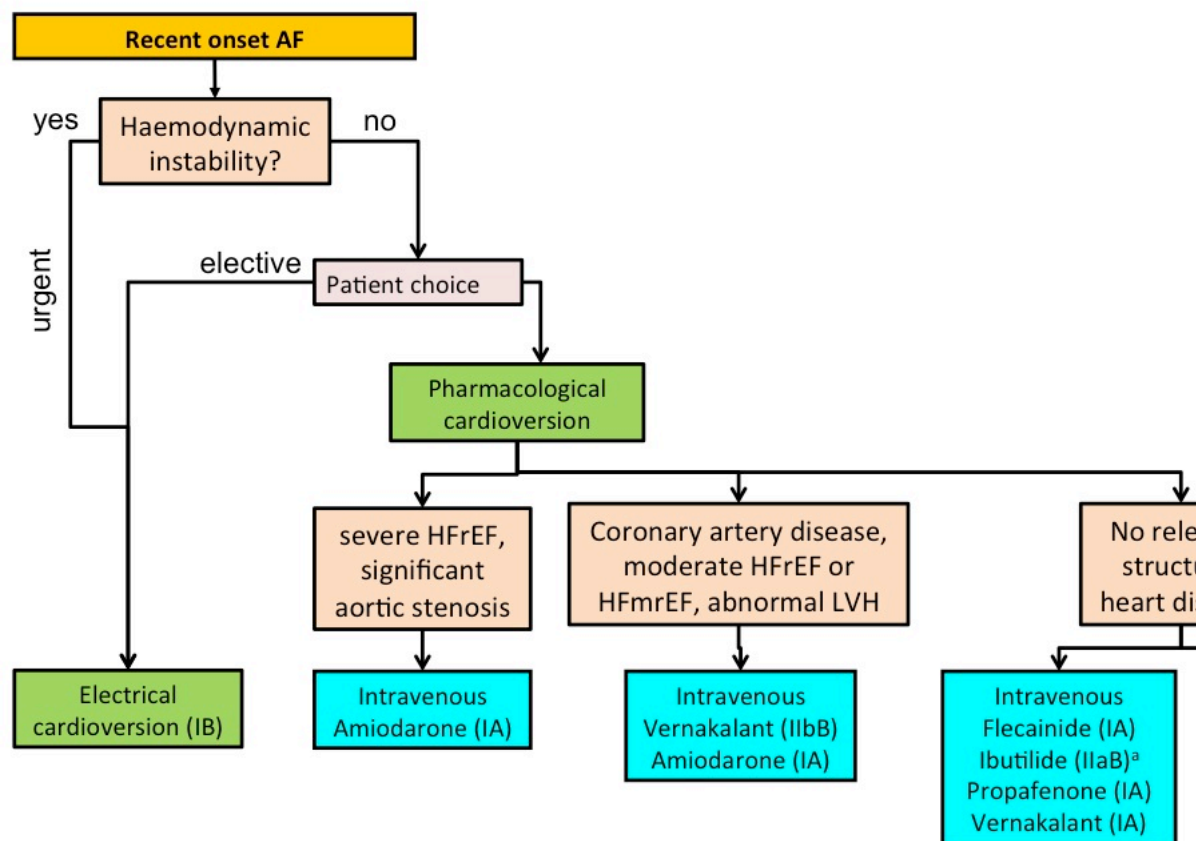
1701 **11.1. Acute restoration of sinus rhythm**

1702 **11.1.1. Antiarrhythmic drugs for acute restoration of sinus rhythm**

1703 **(‘pharmacological cardioversion’)**

1704 Antiarrhythmic drug can restore sinus rhythm in patients with AF (pharmacological cardioversion) as
1705 shown in small controlled trials, meta-analyses,^{41, 584, 595, 596} and in a few larger controlled trials.⁵⁹⁷⁻⁶⁰⁵
1706 Outside of Europe, dofetilide is available and can convert recent-onset AF.⁶⁰⁶ Pharmacological cardioversion
1707 restores sinus rhythm in approximately 50% of patients with recent-onset AF (*Table 16*).⁶⁰⁷⁻⁶⁰⁹ In the short term,
1708 electrical cardioversion restores sinus rhythm quicker and more effectively than pharmacological cardioversion
1709 and is associated with shorter hospitalization.⁶⁰⁹⁻⁶¹³ Pharmacological cardioversion, conversely, does not require
1710 sedation or fasting (*Figure 16*).

1711 Flecainide and propafenone are effective for pharmacological cardioversion,^{595, 602-605, 614, 615} but their
1712 use is restricted largely to patients without structural heart disease. Ibutilide is an alternative where available,
1713 but carries a risk of torsades de pointes.⁶¹⁵ Vernakalant⁶⁰²⁻⁶⁰⁵ can be given to patients with mild heart failure
1714 (NYHA Class I or II), including those with ischaemic heart disease, provided they do not present with
1715 hypotension or severe aortic stenosis.⁶¹⁶⁻⁶¹⁸ Amiodarone can be used in patients with heart failure and in patients
1716 with ischaemic heart disease (although patients with severe heart failure were excluded in most of the AF
1717 cardioversion trials).⁵⁹⁶ Amiodarone also slows heart rate by 10–12 bpm after 8–12 hours when given
1718 intravenously.⁵⁹⁶ Both amiodarone and flecainide appear more effective than sotalol in restoring sinus
1719 rhythm.^{600, 601, 619}



1720

1721 **Figure 16** Rhythm control management of acute AF.1722 AF = atrial fibrillation; HFmrEF = heart failure with mid-range ejection fraction; HFrEF = heart failure with
1723 reduced ejection fraction.1724 ^aIbutilide should not be used in patients with long QT interval.

1725

1726 **11.1.2. ‘Pill in the pocket’ cardioversion performed by patients**

1727 In selected patients with infrequent symptomatic episodes of paroxysmal AF, a single bolus of oral flecainide
1728 (200–300 mg) or propafenone (450–600 mg) can be self-administered by the patient at home (‘pill in the pocket’
1729 therapy) to restore sinus rhythm, after safety has been established in the hospital setting.⁶²⁰ This approach seems
1730 marginally less effective than hospital-based cardioversion,⁶²¹ but is practical and provides control and
1731 reassurance to selected patients.

1732

1733 **Table 16** Antiarrhythmic drugs for pharmacological cardioversion

Drug	Route	First dose	Follow-up dose	Risks	References
Flecainide	Oral	200–300 mg	N/A	Avoid in patients with IHD and/or significant structural heart disease. Hypotension, atrial flutter with 1:1 conduction, QT prolongation	595, 598
	IV	1.5–2 mg/kg over 10 min			
Amiodarone	IV ^a	5–7 mg/kg over 1–2 h	50 mg/h to a maximum of 1.0 g over 24 h	Phlebitis, hypotension, bradycardia/AV block. Will slow ventricular rate. Delayed conversion to sinus rhythm (8–12 h)	596–601
Propafenone	IV	1.5–2 mg/kg over 10 min		Avoid in patients with IHD and/or significant structural heart disease. Hypotension, atrial flutter with 1:1	622–625

	Oral	450–600 mg		conduction, QRS prolongation (mild)	
Ibutilide^b	IV	1 mg over 10 min	1 mg over 10 min after waiting for 10 min	Avoid in patients with QT prolongation, hypokalemia, severe LVH, or low ejection fraction. QT prolongation, polymorphic ventricular tachycardia/torsades de pointes (3–4% of patients). Will slow ventricular rate	614, 615
Vernakalant	IV	3 mg/kg over 10 min	2 mg/kg over 10 min after waiting for 15 min	Avoid in patients with systolic blood pressure < 100 mmHg, recent (< 30 days) ACS, NYHA Class III and IV heart failure, QT interval prolongation (uncorrected QT > 440 ms), and severe aortic stenosis. Hypotension, non-sustained ventricular arrhythmias, QT and QRS prolongation	602-605, 618

1734 ACS = acute coronary syndromes; IHD = ischaemic heart disease; IV = intravenous; LVH = left ventricular
 1735 hypertrophy; NYHA = New York Heart Association.

1736 ^aUse a large peripheral vessel and change to oral amiodarone within 24 h of IV (central line) administration.

1737 ^bIbutilide is only available in selected European countries.

1738

1739 11.1.3. Electrical cardioversion

1740 Synchronized direct current electrical cardioversion quickly and effectively converts AF to sinus rhythm and is
 1741 the method of choice in severely haemodynamically compromised patients with new-onset AF (*Figure 16*).⁶²⁶⁻
 1742 ⁶²⁸Electrical cardioversion can be performed safely in sedated patients treated with intravenous midazolam
 1743 and/or propofol. Continuous monitoring of blood pressure and oximetry during the procedure is important.⁶²⁹
 1744 Skin burns may occasionally be observed. Intravenous atropine or isoproterenol or temporary transcutaneous
 1745 pacing should be available to mitigate post-cardioversion bradycardia. Biphasic defibrillators are more effective
 1746 than monophasic waveforms, and have become industry standard.^{626, 628} Anterior–posterior electrode positions
 1747 generate a stronger shock field in the left atrium than anterolaterally positioned electrodes, and restore sinus
 1748 rhythm more effectively.^{626, 627, 630}

1749 Pretreatment with amiodarone (requiring a few weeks of therapy),^{631, 632} sotalol,⁶³¹ ibutilide,⁶³³ or
 1750 vernakalant⁶³⁴ can improve efficacy of electrical cardioversion, and similar effects are likely for flecainide⁵⁸⁴
 1751 and propafenone.⁶³⁵ Beta-blockers,⁶³⁶ verapamil, diltiazem,⁶³⁷⁻⁶³⁹ and digoxin^{640, 641} do not reliably terminate AF
 1752 or facilitate electrical cardioversion. When antiarrhythmic drug therapy is planned to maintain sinus rhythm
 1753 after cardioversion, it seems prudent to start therapy 1–3 days before cardioversion (amiodarone: a few weeks)
 1754 to promote pharmacological conversion and to achieve effective drug levels.^{584, 601}

1755

1756 11.1.4. Anticoagulation in patients undergoing cardioversion

1757 Cardioversion carries an inherent risk of stroke in non-anticoagulated patients,⁶⁴² which is reduced substantially
 1758 by the administration of anticoagulation.⁶⁴³ Immediate initiation of anticoagulation is important in all patients
 1759 scheduled for cardioversion.⁶⁴⁴⁻⁶⁴⁶ Patients who have been in AF for longer than 48 hours should start OAC at
 1760 least 3 weeks before cardioversion and continue it for 4 weeks afterwards (in patients without a need for long-
 1761 term anticoagulation), and continue it indefinitely in patients at risk of stroke. This practice has never been
 1762 evaluated in controlled trials, but seemed safe in a large observational data set from Finland.⁶⁴⁷ When early
 1763 cardioversion is desired, TOE can exclude the majority of left atrial thrombi, allowing immediate
 1764 cardioversion.^{648, 649} Ongoing studies will inform about the safety and efficacy of newly initiated anticoagulation
 1765 using NOACs in patients scheduled for electrical cardioversion.

1766

1767 11.2. Long-term antiarrhythmic drug therapy

1768 The aim of antiarrhythmic drug therapy is improvement in AF-related symptoms.^{41, 580} Hence, the decision to
 1769 initiate long-term antiarrhythmic drug therapy needs to balance symptom burden, possible adverse drug
 1770 reactions, and patient preferences. The principles of antiarrhythmic drug therapy outlined in the 2010 ESC AF
 1771 guidelines³⁶⁹ are still relevant and should be observed:

- 1772 1. Treatment is aimed at reducing AF-related symptoms;
- 1773 2. Efficacy of antiarrhythmic drugs to maintain sinus rhythm is modest;

- 1774 3. Clinically successful antiarrhythmic drug therapy may reduce rather than eliminate the recurrence of
1775 AF;
1776 4. If one antiarrhythmic drug ‘fails’, a clinically acceptable response may be achieved with another agent;
1777 5. Drug-induced proarrhythmia or extra-cardiac side-effects are frequent;
1778 6. Safety rather than efficacy considerations should primarily guide the choice of antiarrhythmic drug.
1779

1780 Antiarrhythmic drug therapy approximately doubles sinus rhythm maintenance compared with no therapy.⁵⁸⁰
1781 There is no appreciable effect on mortality or cardiovascular complications, but rhythm control therapy can
1782 slightly increase the risk of hospitalizations (often for AF).^{41, 578, 579, 582, 589-593} To reduce the risk of side-
1783 effects,^{201, 580} a shorter duration of antiarrhythmic drug therapy seems desirable. As an example, short-term
1784 treatment (4 weeks) with flecainide for 4 weeks after cardioversion of AF was well-tolerated and prevented
1785 most (80%) AF recurrences when compared with long-term treatment.⁵⁸⁴ Short-term antiarrhythmic drug
1786 therapy is also used to avoid early AF recurrences after catheter ablation⁶⁵⁰ and may be reasonable in patients
1787 deemed at increased risk of antiarrhythmic drug side-effects or in those with a low perceived risk of recurrent
1788 AF.

1789 In addition to antiarrhythmic drug therapy and catheter ablation (see Section 10.3), management of
1790 concomitant cardiovascular conditions can reduce symptom burden in AF and facilitate maintenance of sinus
1791 rhythm.^{203, 204, 296, 312} This includes weight reduction, blood pressure control, heart failure treatment, increasing
1792 cardiorespiratory fitness, and other measures (see Chapter 6).
1793

1794 11.2.1. Selection of antiarrhythmic drugs for long-term therapy: Safety first!

1795 Usually, the safety of antiarrhythmic drug therapy determines the initial choice of antiarrhythmic drugs (*Figure*
1796 *17*). The following major antiarrhythmic drugs are available to prevent AF:
1797

1798 **Amiodarone** is an effective multichannel blocker, reduces ventricular rate, and is safe in patients with heart
1799 failure.^{582, 651} Torsades de pointes proarrhythmia can occur, and QT interval and TU waves should be monitored
1800 on therapy (see *Table 17*).⁶⁵² Amiodarone often causes extracardiac side-effects, especially on long-term
1801 therapy,^{653, 654} rendering it a second-line treatment in patients who are suitable for other antiarrhythmic drugs.
1802 Amiodarone appears less suitable to episodic short-term therapy (unless after catheter ablation),⁶⁵⁵ probably
1803 because of its long biological half-life.
1804

1805 **Dronedarone** maintains sinus rhythm, reduces ventricular rate, and prevents cardiovascular hospitalizations
1806 (mostly due to AF) and cardiovascular death in patients with paroxysmal or persistent AF or flutter who had at
1807 least one relevant cardiovascular comorbidity.^{583, 588, 656} Dronedarone increases mortality in patients with
1808 recently decompensated heart failure (with or without AF)⁶⁵⁷ and in patients with permanent AF in whom sinus
1809 rhythm is not restored.⁶⁵⁸ Dronedarone moderately increases serum creatinine, reflecting a reduction in
1810 creatinine excretion rather than a decline in kidney function.⁶⁵⁹
1811

1812 **Flecainide** and **propafenone** are effective in preventing recurrent AF.^{581, 584, 620} They should only be used in
1813 patients without significant ischaemic heart disease or heart failure to avoid the risk of life-threatening
1814 ventricular arrhythmias.⁶⁶⁰ High ventricular rates resulting from the conversion of AF into atrial flutter with 1:1
1815 conduction by flecainide or propafenone can be prevented by preadministering a beta-blocker, verapamil, or
1816 diltiazem.
1817

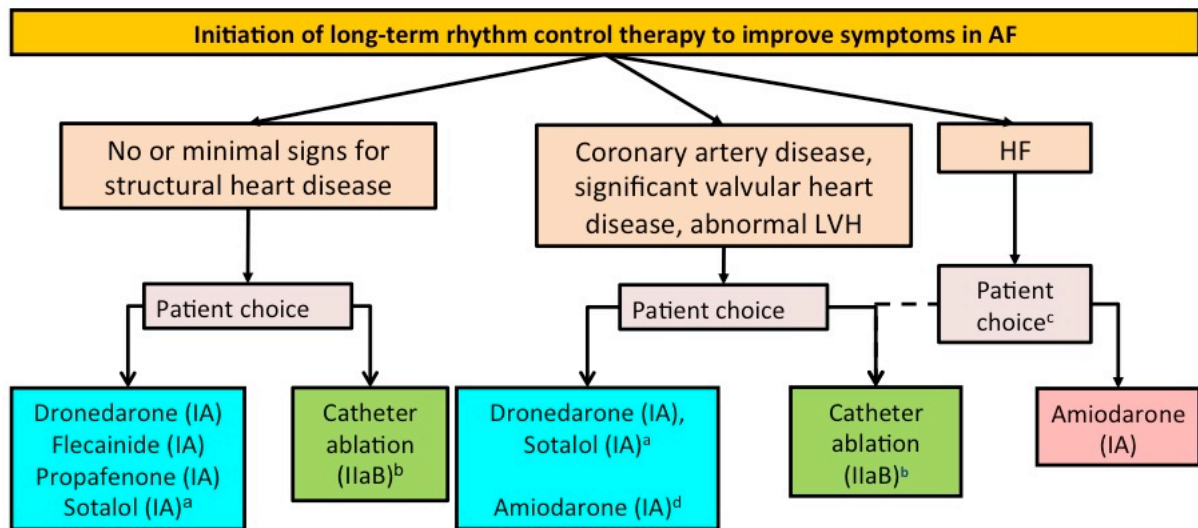
1818 **Quinidine** and **disopyramide** have been associated with an increase in all-cause mortality (OR 2.39; 95% CI
1819 1.03–5.59; number needed to harm 109; 95% CI 34–4985) at 1-year follow-up,^{580, 661} likely due to ventricular
1820 arrhythmias (torsades de pointes).^{580, 661} Although this proarrhythmic effect is more common at higher doses,
1821 they are less commonly used for rhythm control in AF. Disopyramide may be useful in ‘vagally mediated’ AF
1822 (e.g. AF occurring in athletes and/or during sleep⁷⁶), and has been shown to reduce LV outflow gradient and
1823 improve symptoms in patients with hypertrophic cardiomyopathy.⁶⁶²⁻⁶⁶⁴
1824

1825 **Sotalol** has a relevant risk of torsades de pointes (1% in the Prevention of Atrial Fibrillation After Cardioversion
1826 [PAFAC] trial¹¹⁸). Its d-enantiomer is associated with an increased mortality compared to placebo in patients
1827 with LV dysfunction post-myocardial infarction,⁶⁶⁵ probably due to ventricular arrhythmias (OR 2.47; 95% CI
1828 1.2–5.05; number needed to harm 166; 95% CI 61–1159).^{580, 665} On the other hand, d,l sotalol has been used in
1829 AF patients without safety signals in two controlled trials.^{581, 601}
1830

1831 **Dofetilide** is another potassium channel blocker that is mainly available outside of Europe. Dofetilide restores
1832 and maintains sinus rhythm in heart failure patients⁶⁶⁶ and occasionally in patients refractory to other
1833 antiarrhythmic drugs.⁶⁶⁷

1834

1835 Overall, it seems prudent to limit the use of quinidine, disopyramide, dofetilide, and sotalol to specific
 1836 situations. Similarly, combinations of QT-prolonging antiarrhythmic drugs should generally be avoided (*Table*
 1837 *17*).



1838

1839 **Figure 17** Initiation of rhythm control therapy in symptomatic patients.

1840 AF = atrial fibrillation; HF = heart failure; LVH = left ventricular hypertrophy;

1841 ^aSotalol requires careful evaluation of proarrhythmic risk.

1842 ^bCatheter ablation should isolate pulmonary veins and can be performed using radiofrequency or cryoballoon catheters.

1844 ^cCatheter ablation as a first-line therapy is usually reserved for heart failure patients with tachycardiomyopathy.

1845 ^dAmiodarone is a second-choice therapy in many patients because of its extracardiac side-effects.

1846

1847 11.2.2. Twelve-lead electrocardiogram as a tool to identify patients at risk of 1848 proarrhythmia

1849 Identifying patients at risk of proarrhythmia can help to mitigate the proarrhythmic risk of antiarrhythmic
 1850 drugs.⁶⁶⁸ In addition to the clinical characteristics mentioned above, monitoring PR, QT, and QRS durations
 1851 during initiation of antiarrhythmic drug therapy can identify patients at higher risk of drug-induced
 1852 proarrhythmia on longer-term treatment.⁶⁶⁹⁻⁶⁷¹ In addition, the presence of ‘abnormal TU waves’ is a sign of
 1853 imminent torsades de pointes.⁶⁵² Periodic ECG analysis for proarrhythmia signs has been used successfully in
 1854 recent antiarrhythmic drug trials.^{118, 584, 672} Specifically, ECG monitoring was used systematically on days 1–3 in
 1855 patients receiving flecainide, propafenone, or sotalol to identify those at risk of proarrhythmia.^{118, 584, 601} Based
 1856 on this evaluated practice, we suggest to record an ECG in all patients before initiation of antiarrhythmic drugs.
 1857 Scheduled ECGs during the initiation period seem reasonable (*Table 17*).

1858

1859 **Table 17** Oral antiarrhythmic drugs used for maintaining sinus rhythm after cardioversion.

Drug	Dose	Main contraindications and precautions	Warning signs warranting discontinuation	Atrioventricular nodal slowing	Suggested ECG monitoring during initiation
Amiodarone	600 mg in divided doses for 4 weeks, 400 mg for 4 weeks, then 200 mg once daily	Caution when using concomitant therapy with QT-prolonging drugs and in patients with sinoatrial node or atrioventricular node and conduction disease. The dose of VKAs and of digitalis should be reduced. Increased risk of myopathy with statins. Caution in patients with pre-existing liver disease	QT prolongation > 500 ms	10–12 bpm in AF	Baseline, 1 week, 4 weeks
Dronedarone	400 mg twice daily	Contraindicated in NYHA class III or IV or unstable heart failure, during concomitant therapy with QT-prolonging drugs, or powerful CYP3A4 inhibitors (e.g. verapamil, diltiazem, azole antifungal agents), and when CrCl < 30 mg/mL. The dose of digitalis, beta-blockers, and of some statins should be reduced. Elevations in serum creatinine of 0.1–0.2 mg/dL are common and do not reflect a decline in renal function. Caution in patients with pre-existing liver disease	QT prolongation > 500 ms	10–12 bpm in AF	Baseline, 1 week, 4 weeks
Flecainide	100–150 mg twice daily	Contraindicated if CrCl < 50 mg/mL, liver disease, IHD, or reduced LVEF.	QRS duration increases > 25% above baseline	None	Baseline, day 1, day 2–3
Flecainide slow release	200 mg once daily	Caution in the presence of sinoatrial node or atrioventricular node or conduction system disease. CYP2D6 inhibitors (e.g. fluoxetine, tricyclic) increase plasma concentration			
Propafenone	150–300 mg three times daily	Contraindicated in IHD or reduced LV ejection fraction. Caution in the presence of sinoatrial node or atrioventricular node and conduction system disease, renal or liver impairment, and asthma. Increases concentration of digitalis and warfarin	QRS duration increase > 25% above baseline	Slight	Baseline, day 1, day 2–3
Propafenone SR	225–425 mg twice daily				
d,l sotalol	80–160 mg twice daily	Contraindicated in the presence of significant LV hypertrophy, systolic heart failure, asthma, pre-existing QT prolongation, hypokalaemia, CrCl < 50 mg/mL. Moderate renal dysfunction requires careful adaptation of dose	QT interval > 500 ms, QT prolongation by > 60 ms upon therapy initiation	Similar to high-dose blockers	Baseline, day 1, day 2–3

1860 AF = atrial fibrillation; bpm = beats per minute; CrCl = creatinine clearance; ECG = electrocardiogram; IHD =
 1861 ischaemic heart disease; LV = left ventricular; LVEF = left ventricular ejection fraction; NYHA = New York
 1862 Heart Association; VKA = vitamin K antagonist.

1863

1864 11.2.3. New antiarrhythmic drugs

1865 Several compounds that inhibit the ultrarapid potassium current (I_{Kur}) and other inhibitors of atypical ion
 1866 channels are in clinical development.⁶⁷³⁻⁶⁷⁵ They are not available for clinical use at present. The antianginal
 1867 compound ranolazine inhibits potassium and sodium currents and increases glucose metabolism at the expense
 1868 of free fatty acid metabolism, thereby enhancing efficient use of oxygen.^{676, 677} Ranolazine was safe in patients
 1869 with non-ST-segment elevation myocardial infarction and unstable angina evaluated in the MERLIN
 1870 (Metabolic Efficiency With Ranolazine for Less Ischemia in Non ST-Elevation Acute Coronary Syndrome)
 1871 trial.⁶⁷⁸ In a post-hoc analysis of continuous ECG recordings obtained during the first 7 days after
 1872 randomization, patients assigned to ranolazine had a trend towards fewer episodes of AF than those on placebo
 1873 (75 [2.4%] vs. 55 [1.7%] patients; $P = 0.08$).⁶⁷⁹ In the HARMONY (A Study to Evaluate the Effect of
 1874 Ranolazine and Dronedaron When Given Alone and in Combination in Patients With Paroxysmal Atrial
 1875 Fibrillation) trial, the highest tested dose of a combination of ranolazine (750 mg twice daily) and dronedarone
 1876 (225 mg twice daily) slightly reduced AF burden in 134 subjects with paroxysmal AF and dual-chamber
 1877 pacemakers.⁶⁸⁰ Small, open-label studies suggest that ranolazine might enhance the antiarrhythmic effect of
 1878 amiodarone for cardioversion,⁶⁸¹⁻⁶⁸³ whereas the results from a controlled trial of ranolazine and the ranolazine-
 1879 dronedarone combination to prevent AHRE in pacemaker patients were ambiguous.⁶⁸⁴ At present, there is
 1880 insufficient evidence to recommend ranolazine as an antiarrhythmic drug, alone or in combination with other
 1881 antiarrhythmic drugs. Of note, the ‘funny channel blocker’ ivabradine, which is used for angina and heart
 1882 failure, increases the risk of AF.⁶⁸⁵

1883

1884 11.2.4. Antiarrhythmic effects of non-antiarrhythmic drugs

1885 ACE inhibitors or ARBs appear to prevent new-onset AF in patients with LV dysfunction and in hypertensive
 1886 patients with LV hypertrophy.^{219, 236, 237, 239, 246, 250, 686} Nephilysin inhibition needs to be studied further, but does
 1887 not seem to enhance this effect.²²⁴ A Danish cohort study also suggested that initial treatment of uncomplicated
 1888 hypertension with ACE inhibitors or ARBs reduces incident AF compared with other hypertensive agents.²⁴⁵
 1889 ARB therapy did not reduce the AF burden in patients with AF without structural heart disease.²⁴¹ Thus, ACE
 1890 inhibitors or ARBs are unlikely to have a relevant direct antiarrhythmic effect. However, it might be justified to
 1891 consider adding ACE inhibitors or ARB therapy to antiarrhythmic drugs to reduce AF recurrences after
 1892 cardioversion.^{248, 249, 687}

1893

1894 Compared with placebo, beta-blockers are associated with a reduced risk of new-onset AF in patients
 1895 with reduced ejection fraction and sinus rhythm.²³ Beta-blockers have also been reported to reduce symptomatic
 1896 AF recurrences,^{580, 636, 688} but this finding may be driven by the beneficial effect of rate control, which will
 1897 render AF more often asymptomatic.

1898

1899 Perioperative statin therapy appeared to reduce the risk of postoperative AF in a number of small
 1900 RCTs^{689, 690}; however, an adequately powered placebo-controlled trial has shown no effect of perioperative
 1901 rosuvastatin therapy on postoperative AF.⁶⁹¹ Statin treatment does not prevent AF in other settings.^{692, 693}
 1902 Similarly, polyunsaturated fatty acids failed to show convincing benefit.^{241, 694-698} The role of aldosterone
 1903 antagonists in the management of AF has not been extensively investigated in humans; although preliminary
 1904 evidence from trials of eplerenone is encouraging for primary prevention,²⁴³ at present there is no robust
 1905 evidence to make any recommendation for the use of aldosterone antagonists for secondary prevention of AF.<sup>699-
 1906 701</sup>

1904

1905

1906 Recommendations for rhythm control therapy

Recommendations	Class ^a	Level ^b	Refs ^d
General recommendations			
Management of cardiovascular risk factors and avoidance of AF triggers should be pursued in patients on rhythm control therapy to facilitate maintenance of sinus rhythm	IIa	B	203, 204, 296, 312
Rhythm control therapy is indicated for symptom improvement in patients with AF	I	B	120, 586, 601
With the exception of AF associated with haemodynamic instability, the choice between electrical and pharmacological cardioversion	IIa	C	

should be guided by patient and physician preferences			
Cardioversion of AF			
Electrical cardioversion of AF is recommended in patients with acute haemodynamic instability to acutely restore cardiac output	I	B	612, 702-704
Cardioversion of AF (either electrical or pharmacological) is recommended in symptomatic patients with persistent or long-standing persistent AF as part of rhythm control therapy	I	B	584, 601, 627, 628, 648, 705
Pretreatment with amiodarone, flecainide, ibutilide, or propafenone should be considered to enhance success of electrical cardioversion and prevent recurrent AF	Ila	B	248, 584, 633
In patients with no history of ischaemic or structural heart disease, flecainide, propafenone, or vernakalant are recommended for pharmacological cardioversion of new-onset AF	I	A	602-605, 614, 618, 622, 706, 707
In patients with no history of ischaemic or structural heart disease, ibutilide should be considered for pharmacological conversion of AF	Ila	B	
In selected patients with recent-onset AF and no significant structural or ischaemic heart disease, a single oral dose of flecainide or propafenone (the 'pill in the pocket' approach) should be considered for patient-led cardioversion, following safety assessment	Ila	B	620, 621
In patients with ischaemic and/or structural heart disease, amiodarone is recommended for cardioversion of AF	I	A	597-601
Vernakalant may be considered as an alternative to amiodarone for pharmacological conversion of AF in patients without hypotension, severe heart failure, or severe structural heart disease (especially aortic stenosis)	Ilb	B	602-605, 616, 618
Stroke prevention in patients designated for cardioversion of AF			
Anticoagulation with heparin or a NOAC should be initiated as soon as possible before every cardioversion of AF or atrial flutter	Ila	B	708, 709
For cardioversion of AF/atrial flutter, effective anticoagulation is recommended for a minimum of 3 weeks before cardioversion	I	B	648, 708
Transoesophageal echocardiography (TOE) is recommended to exclude cardiac thrombus, as an alternative to preprocedural anticoagulation when early cardioversion is planned	I	B	648, 708
Early cardioversion can be performed without TOE in patients with a definite duration of AF < 48 hours	Ila	B	648
In patients at risk for stroke (e.g. presence of CHA ₂ DS ₂ -VASc factors), anticoagulant therapy should be continued long-term after cardioversion according to the long-term anticoagulation recommendations, irrespective of the method of cardioversion or the apparent maintenance of sinus rhythm. In patients without stroke risk factors, anticoagulation is recommended for 4 weeks after cardioversion	I	B	353, 710
In patients where thrombus is identified on TOE, effective anticoagulation is recommended for at least 3 weeks	I	C	
A repeat TOE to ensure thrombus resolution should be considered before cardioversion	Ila	C	
Antiarrhythmic drugs for the long-term maintenance of sinus rhythm/prevention of recurrent AF			

The choice of antiarrhythmic drug needs to be carefully evaluated, taking into account the presence of comorbidities, cardiovascular risk and potential for serious proarrhythmia, extracardiac toxic effects, patient preferences, and symptom burden	I	A	41, 580
Dronedaron, flecainide, propafenone, or sotalol are recommended for prevention of recurrent symptomatic AF in patients with normal left ventricular function and without pathological left ventricular hypertrophy.	I	A	581, 583, 584, 588, 601
Dronedaron is recommended for prevention of recurrent symptomatic AF in patients with stable coronary artery disease, and without heart failure	I	A	583, 588
Amiodarone is recommended for prevention of recurrent symptomatic AF in patients with heart failure	I	B	596-598
Amiodarone is more effective in preventing AF recurrences than other antiarrhythmic drugs but extracardiac toxic effects are common and increase with time. For this reason, other antiarrhythmic drugs should be considered first	IIa	C	596-598
Patients on antiarrhythmic drug therapy should be periodically evaluated to confirm their eligibility for treatment	IIa	C	583, 588, 657, 658, 660
ECG recording during the initiation of antiarrhythmic drug therapy should be considered to monitor heart rate, detect QRS and QT interval prolongation, and the occurrence of atrioventricular block	IIa	B	584 582, 583, 588, 601
Antiarrhythmic drug therapy is not recommended in patients with prolonged QT interval (> 0.5 s) or with significant sinoatrial node disease or atrioventricular node dysfunction who do not have a functioning permanent pacemaker	III (harm)	C	
Adding atrial-based bradycardia pacing to drug treatment that induces or exacerbates sinus node dysfunction should be considered to allow continuation of antiarrhythmic drug therapy in patients in whom AF ablation is declined or not indicated	IIa	B	711, 712
Continuation of antiarrhythmic drug therapy beyond the blanking period after AF ablation should be considered to maintain sinus rhythm when recurrences seem likely	IIa	B	713
Antiarrhythmic effects of non-antiarrhythmic drugs			
ACE inhibitors, ARBs, and beta-blockers should be considered for prevention of new-onset AF in patients with heart failure and reduced ejection fraction	IIa	A	23, 219, 236, 237, 239, 250, 714
ACE inhibitors and ARBs should be considered for prevention of new-onset AF in patients with hypertension, particularly with LV hypertrophy	IIa	B	238, 246, 686, 714
Pretreatment with ACE inhibitors or ARBs may be considered in patients with recurrent AF undergoing electrical cardioversion and receiving antiarrhythmic drug therapy	IIb	B	236, 237, 248, 249
ARBs or ACE inhibitors are not recommended for the secondary prevention of paroxysmal AF in patients with little or no underlying heart disease.	III (no benefit)	B	241, 697

1907 ACE = angiotensin-converting enzyme; AF = atrial fibrillation; ARB = angiotensin receptor blocker; CHA₂DS₂-
1908 VASc = Congestive Heart failure, hypertension, Age ≥75 (doubled), Diabetes, Stroke (doubled), Vascular
1909 disease, Age 65–74, and Sex (female); ECG = electrocardiogram; NOAC = non-vitamin K antagonist oral
1910 anticoagulant; TOE = transoesophageal echocardiography.

1911 ^aClass of recommendation.

1912 ^bLevel of evidence.

1913 ^cReference(s) supporting recommendations.

1914

1915 **11.3. Catheter ablation**

1916 Since the initial description of triggers in the pulmonary veins that initiate paroxysmal AF,¹⁰⁸ catheter ablation
 1917 of AF has developed from a specialized, experimental procedure into a common treatment to prevent recurrent
 1918 AF.^{587, 715} This is primarily achieved through isolation of the pulmonary veins, probably requiring complete
 1919 isolation for full effectiveness,⁷¹⁶ and additional ablation in the posterior left atrial wall. AF ablation, when
 1920 performed in experienced centres by adequately trained teams, is more effective than antiarrhythmic drug
 1921 therapy in maintaining sinus rhythm, and the complication rate, though not negligible, is similar to the
 1922 complication rate for antiarrhythmic drugs.^{585, 717, 1042}

1924 11.3.1. Indications

1925 Catheter ablation of AF is effective in restoring and maintaining sinus rhythm in patients with symptomatic
 1926 paroxysmal, persistent, and probably long-standing persistent AF – in general as second-line treatment after
 1927 failure of or intolerance to antiarrhythmic drug therapy. In such patients, catheter ablation is more effective than
 1928 antiarrhythmic drug therapy.^{185, 586, 713, 717-720} As first-line treatment for paroxysmal AF, randomized trials
 1929 showed only modestly improved rhythm outcome with catheter ablation compared to antiarrhythmic drug
 1930 therapy.^{585, 721-723} Complication rates were similar, but ablation was performed in expert centres, justifying
 1931 catheter ablation as first-line therapy in selected patients with paroxysmal AF who ask for interventional
 1932 therapy. Fewer data are available reporting the effectiveness and safety of catheter ablation in patients with
 1933 persistent or long-standing persistent AF, but all point to lower recurrence rates after catheter ablation compared
 1934 to antiarrhythmic drug therapy with or without cardioversion.^{185, 717, 723-726, 1039} In patients who experience
 1935 symptomatic recurrences of AF despite antiarrhythmic drug therapy, all RCTs showed better sinus rhythm
 1936 maintenance with catheter ablation than on antiarrhythmic drugs.^{586, 713, 727, 728} There is no current indication for
 1937 catheter ablation to prevent cardiovascular outcomes (or desired withdrawal of anticoagulation), or to reduce
 1938 hospitalization.^{40, 594}

1940 11.3.2. Techniques and technologies

1941 Complete pulmonary vein isolation (PVI) on an atrial level is the best documented target for catheter
 1942 ablation,^{716, 729-731} achievable by point-by-point radiofrequency ablation, linear lesions encircling the pulmonary
 1943 veins, or cryoballoon ablation, with similar outcomes.⁷³²⁻⁷³⁴ Complete isolation of the pulmonary veins has
 1944 better rhythm outcomes than incomplete isolation.⁷¹⁶ PVI was initially tested in patients with paroxysmal AF,
 1945 but appears to be non-inferior to more extensive ablation in persistent AF as well.^{729, 735} More extensive
 1946 ablations have been used in patients with persistent AF, but there are insufficient data to guide the use of these at
 1947 present.^{117, 718, 719, 735-737} Extended ablation procedures (beyond PVI) consistently require longer procedures and
 1948 more ionizing radiation, potentially creating risk for patients. Left atrial macro-reentrant tachycardia is relatively
 1949 uncommon after PVI ($\approx 5\%$). It also seems even less common after cryoballoon ablation,⁷³⁴ but may occur in up
 1950 to 25% of patients after left atrial substrate modification ablation, often due to incomplete ablation lines. Thus,
 1951 for patients with persistent AF, ablation of complex fractionated electrograms, ablation of rotors, or routine
 1952 deployment of linear lesions or other additional ablations does not seem justified in the first procedure.^{735, 738, 739}
 1953 However, additional ablation on top of complete PVI⁷¹⁶ may be considered in patients with recurrent AF after
 1954 the initial ablation procedure.^{719, 740, 741} In patients with documented right atrial isthmus-dependent flutter
 1955 undergoing AF ablation, right atrial isthmus ablation is recommended. Adenosine testing to identify patients in
 1956 need of additional ablation remains controversial after evaluation in several reports.^{739, 742-744} Ablation of so-
 1957 called ‘rotors’ guided by body surface mapping or endocardial mapping is under evaluation and cannot be
 1958 recommended for routine clinical use at present.

1960 11.3.3. Outcome and complications

1961 The rhythm outcome after catheter ablation of AF is difficult to predict in individual patients.^{173, 227, 713, 728} Most
 1962 patients require more than one procedure to achieve symptom control.^{713, 726, 728} In general, better rhythm
 1963 outcome and lower procedure-related complications can be expected in younger patients with a short history of
 1964 AF and frequent, short AF episodes in the absence of significant structural heart disease.⁷⁴⁵ Catheter ablation is
 1965 more effective than antiarrhythmic drug therapy in maintaining sinus rhythm (*Web Addenda Figure 2*).^{746, 1039}
 1966 Sinus rhythm without severely symptomatic recurrences of AF is found in up to 70% of patients with
 1967 paroxysmal AF, and around 50% in persistent AF.^{713, 728, 735, 1042} Very late recurrence of AF after years of sinus
 1968 rhythm is not uncommon and may reflect disease progression, with important implications for continuation of
 1969 AF therapies.⁷²⁸ Multiple variables have been identified as risk factors for recurrence after catheter ablation of
 1970 AF, but their predictive power is weak. The decision for catheter ablation thus should be based on a shared
 1971 decision-making process⁷⁴⁷ (see Chapter 7), following thorough explanation of the potential benefits and risks,
 1972 and of the alternatives such as antiarrhythmic drug or acceptance of current symptoms without rhythm control
 1973 therapy.¹⁷⁵

1974 *Complications of catheter ablation for AF*

1975 There is a clear need to systematically capture complications in clinical practice to improve the quality of AF
 1976 ablation procedures.¹⁷⁵ The median length of hospital stay in AF patients undergoing their first ablation as part
 1977 of the EURObservational Research Programme (EORP) was 3 days (interquartile range 2–4 days), based on
 1978 data from 1391 patients from hospitals performing at least 50 ablations per year. Five to seven per cent of
 1979 patients will suffer severe complications after catheter ablation of AF, and 2–3% will experience life-threatening
 1980 but usually manageable complications.^{727, 748-750} Intraprocedural death has been reported, but is rare (< 0.2%).⁷⁵¹
 1981 The most important severe complications are stroke/TIA (< 1%), cardiac tamponade (1–2%), pulmonary vein
 1982 stenosis, and severe oesophageal injury leading to atrio-oesophageal fistula weeks after ablation (*Table 18*).
 1983 ‘Silent strokes’ (i.e. white matter lesions detectable by brain MRI), have been observed in around 10% of
 1984 patients treated with radiofrequency and cryoballoon ablation.⁷⁵² The clinical relevance of this observation is
 1985 unclear.⁷⁴⁹ Post-procedure complications include stroke, with the highest risk within the first week,⁷⁵³ late
 1986 pericardial tamponade several days after catheter ablation,⁷⁵¹ and oesophageal fistulas, which usually become
 1987 apparent 7–30 days after ablation. Timely detection of atrio-oesophageal fistulas can be life-saving and should
 1988 be based on the typical triad of infection without a clear focus, retrosternal pain, and stroke or TIA.⁷⁴⁸
 1989

1990 **Table 18** Complications related to catheter ablation of AF

Complication severity	Complication type	Rate ^{727, 748, 750, 754-759}
Life-threatening complications	Periprocedural death	< 0.2%
	Oesophageal injury (perforation/fistula) ^a	< 0.5%
	Periprocedural stroke (including TIA/air embolism)	< 1%
	Cardiac tamponade	1–2%
Severe complications	Pulmonary vein stenosis	< 1%
	Persistent phrenic nerve palsy	1–2%
	Vascular complications	2–4%
	Other severe complications	≈ 1%
Other moderate or minor complications		1–2%
Unknown significance	Asymptomatic cerebral embolism (silent stroke) ^b	5–20%
	Radiation exposure	

1991 AF = atrial fibrillation; TIA = transient ischaemic attack.

1992 ^aOesophageal fistula should be suspected in patients presenting with the triad of unspecific signs of infection,
 1993 chest pain, and stroke or TIA in the first weeks after an ablation procedure. It requires immediate therapy.1994 ^b< 10% for cryoablation or radiofrequency ablation, > 20% for phased radiofrequency ablation

1995

1996 **11.3.4. Anticoagulation – before, during, and after ablation**1997 Patients anticoagulated with VKAs should continue therapy during ablation (with an INR of 2–3).⁷⁶⁰1998 Anticoagulation with NOACs is an alternative to warfarin.^{478, 761-765} There is no safety signal from observational
 1999 cohorts treated with uninterrupted NOAC therapy undergoing catheter ablation in experienced centres.^{761, 763, 766,}2000 ⁷⁶⁷ The first controlled trial, enrolling around 200 patients, has recently been published,⁷⁶⁸ as well as several
 2001 observational data sets.^{761, 769, 770} Ongoing studies compare uninterrupted VKA with NOAC therapy in AF2002 patients undergoing ablation (e.g. AXAFA – AFNET 5 [Apixaban During Atrial Fibrillation Catheter Ablation:
 2003 Comparison to Vitamin K Antagonist Therapy – Anticoagulation using the direct factor Xa inhibitor apixaban2004 during Atrial Fibrillation catheter Ablation: Comparison to vitamin K antagonist therapy; NCT02227550] and
 2005 RE-CIRCUIT [Randomized Evaluation of dabigatran etexilate Compared to warfarin in pulmonaRy vein

2006 ablation: assessment of different peri-procedural anticoagulation strategies; NCT02348723]). During ablation,
2007 heparin should be given to maintain an activated clotting time > 300 seconds. Anticoagulation should be
2008 maintained for at least 8 weeks after ablation for all patients. The true incidence of thromboembolic events after
2009 catheter ablation has never been systematically studied and the expected stroke risk has been adopted from non-
2010 ablation AF cohorts. Although observational studies suggest a relatively low stroke rate in the first few years
2011 after catheter ablation of AF,^{737, 771-776} the long-term risk of recurrent AF and the safety profile of
2012 anticoagulation in ablated patients need to be considered. In the absence of controlled trial data, OAC after
2013 catheter ablation should follow general anticoagulation recommendations, regardless of the presumed rhythm
2014 outcome.

2016 **11.3.5. Ablation of atrial fibrillation in heart failure patients**

2017 Catheter ablation, compared with amiodarone therapy, significantly reduces recurrent AF in AF patients with
2018 HFrEF.⁷⁷⁷ Selected patients with HFrEF and AF can achieve recovery of LV systolic function after catheter
2019 ablation (probably reflecting tachycardiomyopathy). Several smaller trials suggest improved LV function after
2020 catheter ablation in HFrEF patients^{185, 226-228, 778, 779} and reduced hospitalizations,^{720, 777} especially in patients
2021 without a previous myocardial infarction.⁷⁸⁰ Larger trials are warranted to confirm these findings. Catheter
2022 ablation can be demanding in these patients. Thus, indications for catheter ablation in HFrEF patients should be
2023 carefully balanced, and the procedures performed in experienced centres.

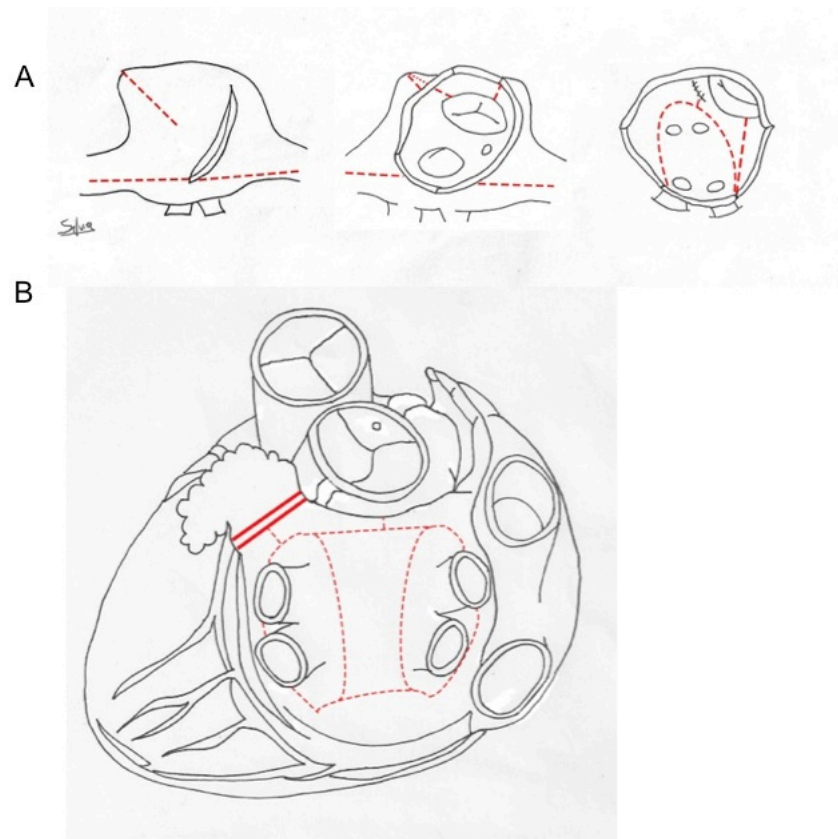
2025 **11.3.6. Follow-up after catheter ablation**

2026 Patients and physicians involved in the follow-up after catheter ablation should know the signs and symptoms of
2027 late complications to allow swift referral for treatment. Patient should also be aware that symptomatic and
2028 asymptomatic AF recurrences are frequent after catheter ablation.^{119, 781, 782} In line with the primary goal of
2029 rhythm control therapy, asymptomatic episodes should generally not trigger further rhythm control therapy.
2030 Patients should be seen at least once by a rhythm specialist in the first 12 months after ablation. Further rhythm
2031 control options should be considered in patients with symptomatic recurrences, including discussion in a Heart
2032 Team (*Figure 17*).

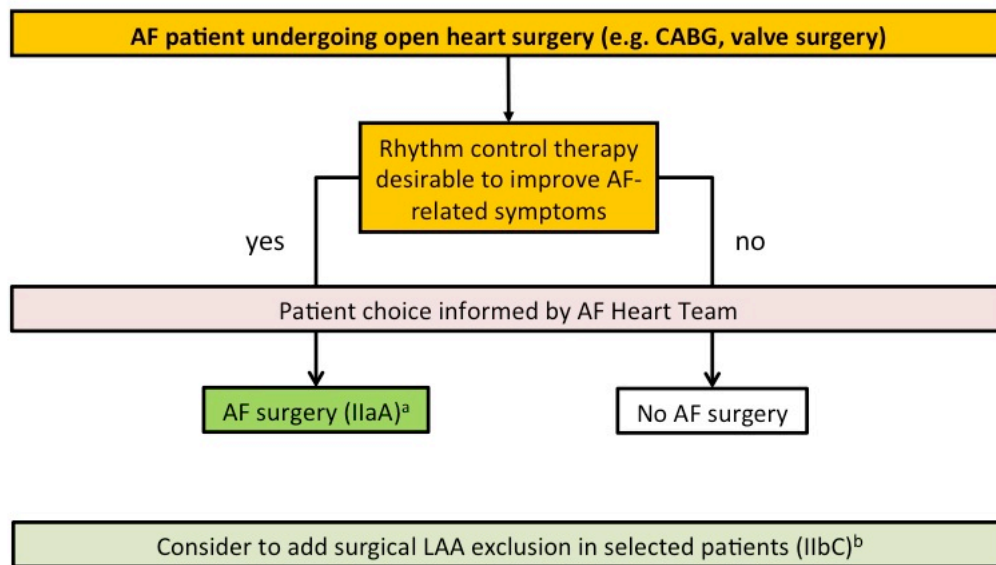
2034 **11.4. Atrial fibrillation surgery**

2035 **11.4.1. Concomitant atrial fibrillation surgery**

2036 The Cox maze procedure was first performed 30 years ago as a ‘cut-and-sew’ technique, including isolation of
2037 the posterior left atrium, a connection to the posterior mitral annulus, a cavotricuspid connection, a cavocaval
2038 connection, and exclusion of the LAA (*Figure 18*).⁷⁸³ Thereby, the Cox maze procedure creates an electrical
2039 labyrinth (maze) of passages through which the sinoatrial node impulse finds a route to the atrioventricular node
2040 while preventing fibrillatory conduction. The Cox maze procedure and other, often simpler, forms of AF surgery
2041 have mainly been used in patients undergoing other open heart surgical procedures.^{461, 466, 784-798} In a systematic
2042 review commissioned for these guidelines, concomitant AF surgery resulted in greater freedom from AF, atrial
2043 flutter, and atrial tachycardia (RR 1.94, 95% CI 1.51–2.49; $n = 554$ from seven RCTs) (*Web Addenda Figure*
2044 *3*).¹⁰⁴⁰ Patients undergoing the Cox maze procedure required pacemaker implantation more often (RR 1.69, 95%
2045 CI 1.12–2.54; $n = 1631$ from 17 RCTs), without a detectable difference in other outcomes or complications.
2046 These findings are underpinned by an analysis of Society of Thoracic Surgeons database comprising 67,389
2047 patients in AF: mortality or major morbidity was not affected by concomitant AF surgery (adjusted OR 1.00;
2048 95% CI 0.83–1.20), but pacemaker implantation was more frequent (adjusted OR 1.26; 95% CI 1.07–1.49).⁷⁹⁹
2049 Predictors of AF recurrence after surgery include left atrial dilatation, older age, > 10-year history of AF, and
2050 non-paroxysmal AF.⁸⁰⁰⁻⁸⁰⁴ Regarding AF type, surgical PVI seems effective in paroxysmal AF.⁸⁰⁵ Batrial lesion
2051 patterns may be more effective in persistent and long-standing persistent AF.^{797, 803, 806} The suggested
2052 management of patients with AF-related symptoms undergoing cardiac surgery is displayed in *Figure 19*, with
2053 an important contribution of the AF Heart Team to advise and inform patient choice.



2054
2055 **Figure 18** A. Surgical lesion sets for the biatrial Cox maze procedure. Left and middle panel: right atrial lesions.
2056 Right panel: left atrial lesions.
2057 B: Left atrial lesions in a thoracoscopic minimally invasive surgical procedure (dashed lines), including left
2058 appendage exclusion (double line).



2059

2060 **Figure 19** Surgical rhythm control in patients undergoing cardiac surgery.2061 AF = atrial fibrillation; CABG = coronary artery bypass graft; LAA = left atrial appendage; PVI = pulmonary
2062 vein isolation.2063 ^aAF surgery may be PVI in paroxysmal AF and biatrial maze in persistent or long-standing persistent AF.2064 ^bOral anticoagulation should be continued in patients at risk of stroke irrespective of AF surgery or LAA
2065 exclusion.

2066

2067

2068

11.4.2. Stand-alone rhythm control surgery2069 Current technology (e.g. bipolar radiofrequency or cryotherapy) renders the procedure easier and more
2070 reproducible and feasible via a mini-thoracotomy.^{786, 807, 808} Thoracoscopic PVI with bipolar radiofrequency2071 prevents recurrence of paroxysmal AF (69–91% freedom from arrhythmias at 1 year, see *Figure 18B* for lesion
2072 set),^{468, 809, 810} and seems effective in patients refractory to catheter ablation.⁸¹¹ The average length of hospital2073 stay for thoracoscopic ablation varies from 3.6 to 6.0 days.^{468, 812, 813} The FAST (Atrial Fibrillation Catheter2074 Ablation vs Surgical Ablation Treatment) trial,⁴⁶⁸ and another smaller trial,⁸¹⁴ suggested that thoracoscopic AF2075 surgery could be more effective than catheter ablation for the maintenance of sinus rhythm,^{468, 814} while also2076 causing more complications (*Table 19*).⁸¹⁵ To improve results,^{468, 816-818} more extensive lesion sets have been2077 performed, connecting lines between the PVI encircling and towards the mitral annulus.^{812, 819-822} To improve the2078 generation of transmural lesions,⁷¹⁶ endo-epicardial ablation strategies have recently been proposed.^{812, 823-825}2079 Although preliminary experience with hybrid simultaneous ablation shows promise, procedural time and rates of
2080 bleeding complications are higher.^{812, 823}

2081

2082

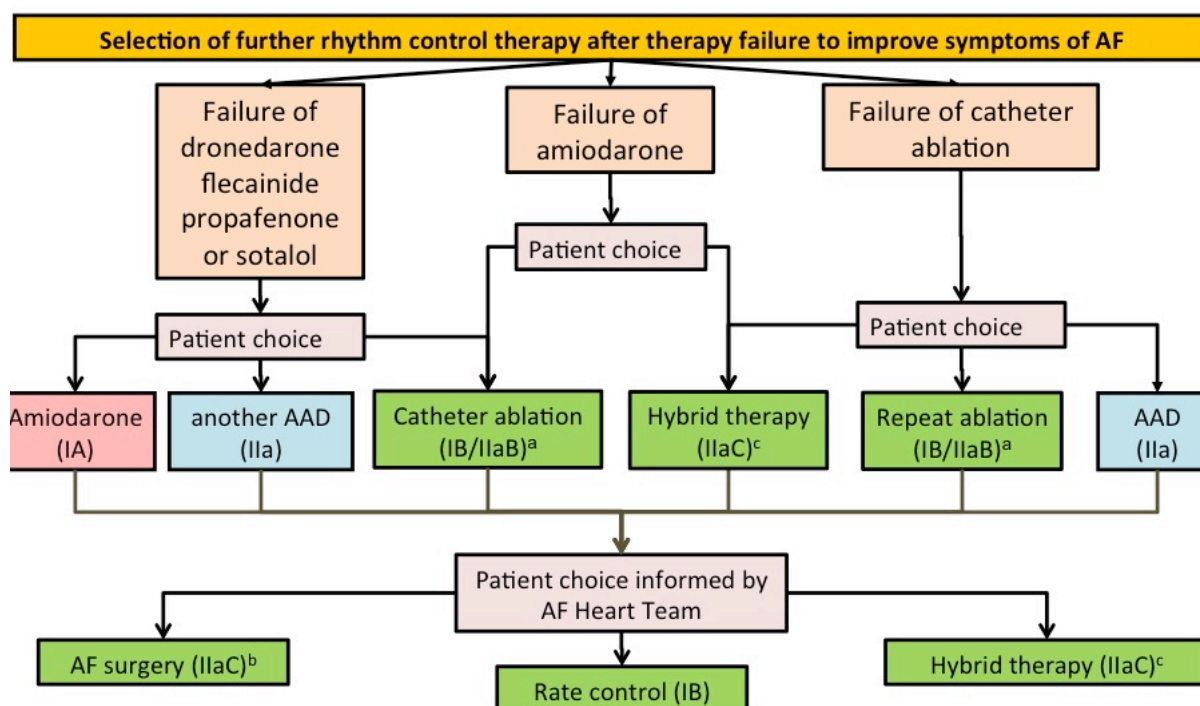
Table 19 Complications of thoracoscopic AF surgery

Complication	Rate ^{468, 815, 822, 826}
Conversion to sternotomy	0–1.6%
Pacemaker implantation	0–3.3%
Drainage for pneumothorax	0–3.3%
Pericardial tamponade	0–6.0%
Transient ischaemic attack ^a	0–3.0%

2083 AF = atrial fibrillation.
 2084 ^aThe rate of asymptomatic cerebral embolism is unknown
 2085

2086 11.5. Choice of rhythm control following treatment failure

2087 There is insufficient evidence on which to base clear recommendations on how to treat patients with recurrent
 2088 AF after catheter ablation. Early recurrences of AF or atrial tachycardias after ablation (occurring within 8
 2089 weeks) may be treated with cardioversion. Many of the published series of patients undergoing AF ablation
 2090 included those who failed antiarrhythmic drug therapy. Thus, considering ablation therapy in patients who have
 2091 symptomatic recurrences on antiarrhythmic drug therapy is often reasonable. Alternatively, trialling another
 2092 antiarrhythmic drug can be considered. Combining antiarrhythmic drug with ablation ('hybrid therapy', see
 2093 Section 11) should be considered based on the different and possibly synergistic effects of these drugs with AF
 2094 ablation, possibly benefitting patients in whom either treatment alone was previously ineffective. Rate control
 2095 without rhythm control, surgical ablation, or repeat catheter ablation should be considered as well as third-line
 2096 options (Figure 20). Patient preferences and local access to therapy are important considerations to inform the
 2097 therapy choice in patients who are in need of further rhythm control therapy after an initial therapy failure.



2098
 2099 **Figure 20** Choice of rhythm control approaches following treatment failure.
 2100 AAD = antiarrhythmic drug; AF = atrial fibrillation; PVI = pulmonary vein isolation.
 2101 ^a catheter ablation should target PVI. Class I level B for paroxysmal AF and Class IIa level B for persistent AF.
 2102 ^b AF surgery may be PVI (e.g. in paroxysmal AF) or maze surgery (e.g. in therapy-refractory or long-standing
 2103 persistent AF).
 2104 ^c Hybrid therapy involves combination of antiarrhythmic drugs, catheter ablation, and/or AF surgery.
 2105

2106 11.6. The atrial fibrillation Heart Team

2107 In view of the complexity of the different treatment options in patients with failed rhythm control therapy but
 2108 who still require or demand further rhythm control therapy, this Task Force proposes that decisions involving
 2109 AF surgery or extensive AF ablation should be based on advice from an AF Heart Team. This will also apply to
 2110 reversal to a rate control strategy in patients with severe (EHRA III or IV) AF symptoms. An AF Heart Team
 2111 should consist of a cardiologist with expertise in antiarrhythmic drug therapy, an interventional
 2112 electrophysiologist, and a cardiac surgeon with expertise in appropriate patient selection, techniques, and

2113 technologies for interventional or surgical AF ablation. Such AF Heart Teams – and a collaborative
 2114 infrastructure supporting a continued interaction between physicians delivering continued care, AF
 2115 cardiologists, interventional electrophysiologists, and AF surgeons – should be established to provide optimal
 2116 advice and ultimately to improve rhythm outcomes for patients in need of advanced and complex rhythm control
 2117 interventions.

2118

2119 **Recommendations for catheter ablation of AF and AF surgery**

Recommendations	Class ^a	Level ^b	Refs ^c
Catheter ablation of symptomatic paroxysmal AF is recommended to improve AF symptoms in patients who have symptomatic recurrences of AF on antiarrhythmic drug therapy (amiodarone, dronedarone, flecainide, propafenone, sotalol) and who prefer further rhythm control therapy, when performed by an electrophysiologist who has received appropriate training and is performing the procedure in an experienced centre	I	A	585-587, 713, 727
Ablation of common atrial flutter should be considered to prevent recurrent flutter as part of an AF-ablation procedure if previously documented or occurring during the AF ablation	IIa	B	827
Catheter ablation of AF should be considered as first-line therapy to prevent recurrent AF and to improve symptoms in selected patients with symptomatic paroxysmal AF as an alternative to antiarrhythmic drug therapy, considering patient choice, benefit, and risk	IIa	B	585
All patients should receive oral anticoagulation for stroke prevention for at least 8 weeks after catheter (IIaB) or surgical (IIaC) ablation.	IIa	B/C	727
Anticoagulation for stroke prevention should be continued indefinitely after apparently successful catheter or surgical ablation of AF in patients at high risk of stroke	IIa	C	
When catheter ablation of AF is planned, continuation of oral anticoagulation with VKA (IIaB) or NOAC (IIaC) should be considered during the procedure, maintaining effective anticoagulation	IIa	B/C	760, 768
Catheter ablation should target complete isolation of the pulmonary veins using radiofrequency ablation or cryotherapy balloon catheters	IIa	B	585, 715, 716, 734, 735
AF ablation should be considered in symptomatic patients with AF and heart failure with reduced ejection fraction to improve symptoms and cardiac function when tachycardiomyopathy is suspected	IIa	C	185, 226-228, 720, 777-779, 828
AF ablation should be considered as a strategy to avoid pacemaker implantation in patients with AF-related bradycardia	IIa	C	829, 830
Catheter or surgical ablation should be considered in patients with symptomatic persistent or long-standing persistent AF refractory to antiarrhythmic drug therapy to improve symptoms, considering patient choice, benefit and risk, supported by an AF Heart Team	IIa	C	468, 735, 777, 831, 832, 1040
Minimally invasive surgery with epicardial pulmonary vein isolation should be considered in patients with symptomatic AF when catheter ablation has failed. Decisions on such patients should be supported by an AF Heart Team	IIa	B	468 812, 819, 823
Maze surgery, possibly via a minimally invasive approach, performed by an adequately trained operator in an experienced centre, should be considered by an AF Heart Team as a treatment option for patients with symptomatic refractory persistent AF or post-ablation AF to improve symptoms	IIa	C	808, 832

Maze surgery, preferably biatrial, should be considered in patients undergoing cardiac surgery to improve symptoms attributable to AF, balancing the added risk of the procedure and the benefit of rhythm control therapy	IIa	A	461, 466, 790, 791, 796, 797
Concomitant biatrial maze or pulmonary vein isolation surgery may be considered in asymptomatic AF patients undergoing cardiac surgery	IIb	C	796, 797, 833

2120 AF = atrial fibrillation; NOAC = non-vitamin K antagonist oral anticoagulant; VKA = vitamin K antagonist.

2121 ^aClass of recommendation.

2122 ^bLevel of evidence.

2123 ^cReference(s) supporting recommendations.

2124

2125 **12 Hybrid rhythm control therapy**

2126 AF has many different drivers, which are only partially targeted by antiarrhythmic drug or catheter ablation.⁹⁶

2127 Hence, combination or 'hybrid' rhythm control therapy seems reasonable, although there is little evidence
2128 supporting its use.

2129

2130 **12.1. Combining antiarrhythmic drugs and catheter ablation**

2131 Antiarrhythmic drug therapy is commonly given for 8–12 weeks after ablation to reduce early recurrences of AF
2132 after catheter ablation, supported by a recent controlled trial where amiodarone halved early AF recurrences
2133 compared with placebo.⁶⁵⁰ Prospective studies have not been done, but a meta-analysis of the available (weak)
2134 evidence suggests slightly better prevention of recurrent AF in patients treated with antiarrhythmic drugs after
2135 catheter ablation.⁷¹³ Many patients are treated with antiarrhythmic drug therapy after catheter ablation (most
2136 often amiodarone or flecainide),⁵⁸⁷ and this seems a reasonable option in patients with recurrent AF after
2137 ablation. It seems common sense to consider antiarrhythmic drug therapy in patients who are in need of further
2138 rhythm control therapy after catheter ablation, but controlled trials to confirm this are desirable.

2139 Combining cavotricuspid isthmus ablation and antiarrhythmic drugs may lead to improved rhythm
2140 control without the need for left atrial ablation in patients who develop 'drug-induced atrial flutter' on therapy
2141 with flecainide, propafenone, or amiodarone,⁸³⁴⁻⁸³⁶ although recurrent AF is a concern in the long term.^{837, 838}

2142

2143 **12.2. Combining antiarrhythmic drugs and pacemakers**

2144 In selected patients with sick sinus syndrome and fast ventricular response during AF paroxysms requiring rate
2145 control therapy, the addition of a pacemaker not only optimizes rate control but may also help to control
2146 rhythm.^{711, 712} Moreover, when antiarrhythmic drug treatment leads to sinus node dysfunction and bradycardia,
2147 pacing may permit up titration of the antiarrhythmic drug dose. Such strategies have never been prospectively
2148 investigated and the existing populations studied are highly selected.^{839, 840} Some patients with AF-induced
2149 bradycardia may benefit from catheter ablation of AF, obviating the need for antiarrhythmic drugs and
2150 pacemaker implantation.^{829, 830}

2151

2152 **13 Specific situations**

2153 **13.1. Frail and 'elderly' patients**

2154 Many AF patients present at an older age (e.g. > 75 or > 80 years). There are no studies suggesting that
2155 cardiovascular risk reduction is less effective in these 'elderly' AF patients than in younger patients. Rather, age
2156 is one of the strongest predictors/risk factors for ischaemic stroke in AF (*Table 11*).³⁸² Good data are available to
2157 support the use of anticoagulants in older patients from BAFTA (Birmingham Atrial Fibrillation Treatment of
2158 the Aged Study),³⁶² the NOAC trials,³⁹ and from analyses in elderly Americans (Medicare).³⁹⁶ Elderly AF
2159 patients are at higher risk of stroke and thus are more likely to benefit from OAC than younger patients,⁸⁴¹ and
2160 yet OAC is still underutilized in the elderly.^{220, 842} Although the evidence base is smaller for other treatment
2161 options in AF, the available data support the use of available rate and rhythm control interventions, including
2162 pacemakers and catheter ablation, without justification to discriminate by age group. Individual patients at older
2163 age may present with multiple comorbidities including dementia, a tendency to falls, CKD, anaemia,
2164 hypertension, diabetes, and cognitive dysfunction. Such conditions may limit quality of life more than AF-
2165 related symptoms. Impairment of renal and hepatic function and multiple simultaneous medications make drug
2166 interactions and adverse drug reactions more likely. Integrated AF management and careful adaptation of drug
2167 dosing seem reasonable to reduce complications of AF therapy in such patients.⁸⁴³

2168

2169 **13.2. Inherited cardiomyopathies, channelopathies, and accessory pathways**

2170 Several inherited cardiac conditions are associated with early-onset AF (*Table 20*). Treatment of the underlying
 2171 cardiac condition is an important contribution to AF management in these young patients (see also ESC
 2172 guidelines on the sudden cardiac death⁸⁴⁴ and hypertrophic cardiomyopathy⁸⁴⁵).

2173

2174 **Table 20 Inherited cardiomyopathies, channelopathies, and pathways associated with AF**

2175

Syndrome	Gene	Functional alteration	AF prevalence	References
Long QT syndrome	KCNQ1 KCNH2 SCN5A ANK2 others	IKs <input type="checkbox"/> IKr <input type="checkbox"/> INa <input type="checkbox"/> INa,K <input type="checkbox"/> Various effects	5–10%	846-850
Brugada syndrome	SCN5A GPDIL SCN1B CACNA1C CACNB2b others	INa <input type="checkbox"/> INa <input type="checkbox"/> INa <input type="checkbox"/> ICa <input type="checkbox"/> ICa <input type="checkbox"/> others	10–20%	851-855
Short QT syndrome	KCNH2 KCNQ1 KCNJ2 CACNA1C CACNB2b	IKr <input type="checkbox"/> IKs <input type="checkbox"/> IK1 <input type="checkbox"/> ICa <input type="checkbox"/> ICa <input type="checkbox"/>	Up to 70%	853, 856-858
Catecholaminergic ventricular tachycardia	RYR2 CASQ2	Abnormal Ca ²⁺ release from sarcoplasmic reticulum	Variable but significant	859-861
Hypertrophic cardiomyopathy	Sarcomeric genes		5–15%	862-864
Wolff–Parkinson–White syndrome	PRKAG		Variable	865
Holt–Oram syndrome	TBX5		Variable	866
Arrhythmogenic right ventricular cardiomyopathy	Several desmosomal genes, unknown gene loci		>40% in patients with VTs	867, 868

2176 AF = atrial fibrillation.

2177

2178 **13.2.1. Wolff–Parkinson–White syndrome**

2179 Patients with pre-excitation and AF are at risk of rapid conduction across the accessory pathway, resulting in a
 2180 fast ventricular rate, possibly ventricular fibrillation, and sudden death. In AF patients with evidence of an
 2181 antegrade accessory pathway, catheter ablation of the pathway is recommended.^{869, 870} This procedure is safe and
 2182 effective and may be considered as a prophylactic treatment strategy.^{871, 872} In AF patients surviving a sudden
 2183 death event with evidence of an accessory pathway, urgent catheter ablation of the pathway is recommended.⁸⁶⁹
 2184 A documented short pre-excited RR interval (< 250 ms) during spontaneous or induced AF is one of the risk
 2185 markers for sudden death in Wolff–Parkinson–White syndrome (WPW) syndrome, in addition to a history of
 2186 symptomatic tachycardia, the presence of multiple accessory pathways, and Ebstein’s anomaly. Intravenous
 2187 procainamide, propafenone, or ajmaline can be used to acutely slow ventricular rate,^{873, 874} whereas digoxin,
 2188 verapamil, and diltiazem are contraindicated.⁸⁷⁵ Intravenous amiodarone should be used with caution, as there
 2189 are case reports of accelerated ventricular rhythms and ventricular fibrillation in patients with pre-excited AF
 2190 receiving intravenous amiodarone infusion.⁸⁷⁶

2191

2192 **13.2.2. Hypertrophic cardiomyopathy**

2193 AF is the most common arrhythmia in patients with hypertrophic cardiomyopathy, affecting approximately one-
 2194 quarter of this population.⁸⁷⁷ Observational data highlight a high stroke risk in hypertrophic cardiomyopathy

2195 patients with AF, confirming the need for OAC.⁸⁷⁸ While there is more experience with VKAs, there are no data
 2196 to suggest that NOACs cannot be used in these patients.⁸⁴⁵ Studies of rate or rhythm control medications in
 2197 patients with hypertrophic cardiomyopathy are relatively scarce. Beta-blockers and diltiazem or verapamil seem
 2198 reasonable treatment options for rate control in these patients. In the absence of significant LV outflow tract
 2199 obstruction, digoxin can be used alone or in combination with beta-blockers.⁸⁴⁵ Amiodarone seems a safe
 2200 antiarrhythmic drug in AF patients with hypertrophic cardiomyopathy,⁸⁷⁹ and expert opinion suggests that
 2201 disopyramide may be beneficial in those with outflow tract obstruction. AF ablation is effective to suppress
 2202 symptomatic AF recurrences.⁸⁸⁰⁻⁸⁸⁴ Surgical treatment of AF may be appropriate in patients with hypertrophic
 2203 cardiomyopathy undergoing surgery (e.g. for LV outflow tract obstruction or mitral valve surgery), but
 2204 experience is limited.

2205 2206 **13.2.3. Channelopathies and arrhythmogenic right ventricular cardiomyopathy**

2207 Many channelopathies and inherited cardiomyopathies are associated with AF. AF prevalence ranges from 5%
 2208 to 20% in patients with long QT syndrome or Brugada syndrome, and is up to 70% in short QT syndrome
 2209 (Table 20).^{853, 856-858} Penetrance of disease phenotype including AF is variable.^{61, 852, 885, 886} Both shortening as
 2210 well as prolongation of the atrial action potential have been demonstrated as likely mechanisms underlying AF
 2211 in these diseases. It seems reasonable to consider antiarrhythmic drugs that reverse the suspected channel defect
 2212 in AF patients with inherited cardiomyopathies (e.g. a sodium channel blocker in LQT3⁸⁵² and quinidine in
 2213 Brugada syndrome⁸⁸⁷). More importantly, new-onset AF in young, otherwise healthy individuals should trigger
 2214 a careful search for such inherited conditions, including clinical history, family history, ECG phenotype, and
 2215 echocardiography and/or other cardiac imaging.

2216 Monogenic defects only account for 3–5% of all patients with AF, even in younger populations.^{846, 848,}
 2217 ⁸⁸⁸⁻⁸⁹⁰ Furthermore, there is no clear link between detected mutations and specific outcomes or therapeutic needs.
 2218 For these reasons, genetic testing is not recommended in the general AF population.⁷⁷ Other guidelines have
 2219 described the indications for genetic testing in patients with inherited arrhythmogenic diseases.^{844, 891}

2220 2221 **Recommendations for inherited cardiomyopathies**

2222 Recommendations	Class^a	Level^b	Refs^c
WPW syndrome			
Catheter ablation of the accessory pathway in WPW patients with AF and rapid conduction over the accessory pathway is recommended to prevent sudden cardiac death	I	B	892-894
Catheter ablation of the accessory pathway is recommended without delay in WPW patients who survive sudden cardiac death	I	C	869
Asymptomatic patients with overt pre-excitation and AF should be considered for accessory pathway ablation after careful counselling	IIa	B	872, 895
Hypertrophic cardiomyopathy			
Lifelong oral anticoagulation to prevent stroke is recommended in hypertrophic cardiomyopathy patients who develop AF	I	B	878
Restoration of sinus rhythm by electrical or pharmacological cardioversion to improve symptoms is recommended in hypertrophic cardiomyopathy patients with symptomatic new-onset AF	I	B	845
In haemodynamically stable hypertrophic cardiomyopathy patients with AF, ventricular rate control using beta-blockers and diltiazem/verapamil is recommended	I	C	845
Treatment of LV outflow tract obstruction should be considered in AF patients with hypertrophic cardiomyopathy to improve symptoms	IIa	B	896
Amiodarone should be considered to achieve rhythm control and maintain sinus rhythm in hypertrophic cardiomyopathy patients	IIa	C	845, 897
Inherited cardiomyopathies and channelopathies			
Targeted genetic testing should be considered in patients with AF and a suspicion of inherited cardiomyopathies or channelopathies based on clinical history, family history, or electrocardiographic phenotype	IIa	A	852

2223 AF = atrial fibrillation; LV = left ventricular; WPW = Wolff–Parkinson–White syndrome.

2224 ^aClass of recommendation.

2225 ^bLevel of evidence.

2226 ^cReference(s) supporting recommendations.

2227

2228 **13.3. Sports and atrial fibrillation**

2229 Physical activity improves cardiovascular health, which translates into a lower risk of AF.⁸⁹⁸ Therefore, physical
 2230 activity is a cornerstone of preventing AF. Intensive sports practice, especially endurance sports (> 1500 h of
 2231 endurance sports practice),⁸⁹⁹ increases the risk of AF later in life,⁹⁰⁰⁻⁹⁰² probably mediated by altered autonomic
 2232 tone, volume load during exercise, atrial hypertrophy, and dilatation.^{903,904} This results in a U-shaped
 2233 relationship of physical activity and incident AF.^{214,898,902,905,906} Detraining can reduce AF in models⁹⁰⁴ and
 2234 reduces ventricular arrhythmias in athletes,⁹⁰⁷ but the role of detraining for AF in human athletes is unknown.
 2235 The management of athletes with AF is similar to general AF management, but requires a few special
 2236 considerations. Clinical risk factors will determine the need for anticoagulation. Sports with direct bodily
 2237 contact or prone to trauma should be avoided in patients on OAC. Beta-blockers are not well tolerated and at
 2238 times prohibited, and digoxin, verapamil, and diltiazem are often not potent enough to slow heart rate during
 2239 exertional AF. Catheter ablation for AF probably has similar outcomes in athletes as in non-athletes,^{908,909} but
 2240 further data are needed. Pill-in-the-pocket therapy has been used as well.⁶²⁰ After ingestion of flecainide or
 2241 propafenone as pill-in-the-pocket, patients should refrain from sports as long as AF persists and until two half-
 2242 lives of the antiarrhythmic drug have elapsed. Prophylactic ablation of the flutter circuit may be considered in
 2243 athletes treated with sodium channel blockers.⁹¹⁰

2244

2245 **Recommendations for physical activity in patients with AF**

Recommendations	Class ^a	Level ^b	Refs ^c
Moderate regular physical activity is recommended to prevent AF, while athletes should be counselled that long-lasting, more intense sports participation can promote AF	I	A	214, 898, 900-902, 905, 906
AF ablation should be considered to prevent recurrent AF in athletes	IIa	B	908, 909
The ventricular rate while exercising with AF should be evaluated in every athlete (by symptoms and/or by monitoring), and titrated rate control should be instituted	IIa	C	
After ingestion of pill-in-the-pocket Class I antiarrhythmic drugs, patients should refrain from sports as long as AF persists and until two half-lives of the antiarrhythmic drug have elapsed	IIa	C	620

2246 AF = atrial fibrillation.

2247 ^aClass of recommendation.2248 ^bLevel of evidence.2249 ^cReference(s) supporting recommendations.

2250

2251 **13.4. Pregnancy**

2252 AF in pregnant women is rare and is usually associated with pre-existing heart disease. AF is associated with
 2253 increased complications for the mother and foetus.^{911,912} Better treatment of congenital heart diseases will
 2254 probably increase the incidence of AF during pregnancy in the future.⁹¹³ Pregnant women with AF should be
 2255 managed as high-risk pregnancies in close collaboration with cardiologists, obstetricians, and neonatologists.

2256

2257 **13.4.1. Rate control**

2258 Owing to a lack of specific data, beta-blockers, verapamil, diltiazem, and digoxin all carry a US Food and Drug
 2259 Administration pregnancy safety category of C (benefits may outweigh risk), except for atenolol (category D:
 2260 positive evidence of risk). Their use should be at the lowest dose and for the shortest time required. None of the
 2261 agents are teratogenic, but they readily cross the placenta.⁹¹⁴ Beta-blockers are commonly used in clinical
 2262 practice (e.g. for management of gestational hypertension and pre-eclampsia), but may be associated with
 2263 intrauterine growth retardation,⁹¹⁵ and hence growth scans after 20 weeks gestation are recommended. Digoxin
 2264 is considered safe for maternal and foetal arrhythmias.⁹¹⁶ There are insufficient data to comment on verapamil or
 2265 diltiazem, hence rate control using beta-blockers and/or digoxin is recommended.⁹¹⁷ With regards to
 2266 breastfeeding, all rate control agents are present in breast milk, although levels of beta-blockers, digoxin, and
 2267 verapamil are too low to be considered harmful. Diltiazem will be present at high levels and should be
 2268 considered second-line treatment.⁹¹⁸

2269

2270 **13.4.2. Rhythm control**

2271 Rhythm control therapy in pregnant patients with AF has only been reported in case studies. Amiodarone is
 2272 associated with severe adverse foetal side-effects and should only be considered for emergency situations.⁹¹⁹
 2273 Flecainide and sotalol can both be used for conversion of foetal arrhythmias without major adverse effects,⁹²⁰
 2274 and thus are likely to be safe to treat maternal symptomatic AF. Electrical cardioversion can be effective for
 2275 restoration of sinus rhythm when tachyarrhythmia is causing haemodynamic instability, with low rates of
 2276 adverse outcomes for both mother and foetus.⁹²¹ However, in view of the risk of foetal distress, electrical
 2277 cardioversion should only be carried out where facilities are available for foetal monitoring and emergency
 2278 caesarean section. As with other emergencies during pregnancy, patients should receive 100% oxygen,
 2279 intravenous access should be established early, and the mother should be positioned in the left lateral position to
 2280 improve venous return.⁹²²

2281

2282 **13.4.3. Anticoagulation**

2283 VKAs should be avoided in the first trimester because of teratogenic effects, and in the 2–4 weeks preceding
 2284 delivery to avoid foetal bleeding. Low-molecular-weight heparins are a safe substitute, as they do not cross the
 2285 placenta.⁹²³ In the third trimester, frequent laboratory checks for adequate anticoagulation (e.g. every 10–14
 2286 days) and corresponding dose adjustments are advised, given that in some women high doses of both VKA and
 2287 heparin may be needed to maintain adequate anticoagulation. Pregnant patients with AF and mechanical
 2288 prosthetic valves who elect to stop VKA treatment in consultation with their specialist team between 6 and 12
 2289 weeks of gestation, should receive continuous, dose-adjusted unfractionated heparin or dose-adjusted
 2290 subcutaneous low-molecular-weight heparin. As only limited data are available about teratogenesis for NOACs,
 2291 these drugs should be avoided during pregnancy.

2292

2293 **Recommendations during pregnancy**

Recommendations	Class ^a	Level ^b	Refs ^c
Electrical cardioversion can be performed safely at all stages of pregnancy, and is recommended in patients who are haemodynamically unstable due to AF, and whenever the risk of ongoing AF is considered high, for the mother or the foetus	I	C	
Anticoagulation is recommended in pregnant patients with AF at risk of stroke. To minimize teratogenic risk and intrauterine bleeding, dose-adjusted heparins are recommended during the first trimester of pregnancy and in the 2–4 weeks before delivery. Vitamin K antagonists or heparin can be used in the remaining parts of the pregnancy	I	B	923
NOACs should be avoided in pregnancy and in women planning a pregnancy	III (harm)	C	

2294 NOAC = non-vitamin K antagonist oral anticoagulants

2295 ^aClass of recommendation.

2296 ^bLevel of evidence.

2297 ^cReference(s) supporting recommendations.

2298

2299 **13.5. Postoperative atrial fibrillation**

2300 AF is common after cardiac surgery (occurring in 15–45% of patients),⁹²⁴⁻⁹²⁶ and is associated with increased
 2301 length of hospital stay and higher rates of complications and mortality.⁹²⁷ Postoperative AF is also not
 2302 uncommon after other major surgery, especially in elderly patients. The treatment of postoperative AF is mainly
 2303 based on studies of patients undergoing cardiac surgery, with much less evidence in the non-cardiac surgery
 2304 setting.

2305

2306 **13.5.1. Prevention of postoperative atrial fibrillation**

2307 Beta-blockers reduce postoperative AF and supraventricular tachycardias, albeit with high heterogeneity and
 2308 moderate risk of bias in a systematic review of published studies (the most commonly studied drug was
 2309 propranolol, with AF in 16.3% of the treatment group vs. 31.7% in the control group).⁹²⁵ In the majority of these
 2310 studies, beta-blockers were administered postoperatively, a regimen supported in a recent meta-analysis.⁹²⁸
 2311 Amiodarone reduced the incidence of postoperative AF compared to a beta-blocker regimen in several meta-
 2312 analyses, also reducing hospital stay.^{925, 929-931}

2313 Despite initial reports from meta-analyses,^{689, 932, 933} preoperative treatment with statins did not prevent
 2314 postoperative AF in a prospective controlled trial.⁹³⁴ Other therapies have also been studied in small, hypothesis-
 2315 generating trials, but have not demonstrated clear beneficial effects. These include magnesium,^{925, 935, 936} n-3
 2316 polyunsaturated fatty acids,⁹³⁷⁻⁹⁴⁵ colchicine,⁹⁴⁶ corticosteroids,^{947, 948} and posterior pericardectomy.⁹⁴⁹
 2317 Postoperative overdrive biatrial pacing has not gained widespread use despite some suggestion of prophylactic
 2318 effects.^{925, 950}
 2319

2320 13.5.2. Anticoagulation

2321 Postoperative AF is associated with an increased early stroke risk, increased morbidity, and 30-day mortality.^{927,}
 2322 ^{951, 952} In the long term, patients with an episode of postoperative AF have a twofold increase in cardiovascular
 2323 mortality and a substantially increased risk of future AF and ischaemic stroke compared with patients that
 2324 remain in sinus rhythm after surgery.⁹⁵²⁻⁹⁵⁸ OAC at discharge has been associated with a reduced long-term
 2325 mortality in patients with postoperative AF,⁹⁵⁹ without evidence from controlled trials. Good quality data are
 2326 needed to determine whether long-term anticoagulation can prevent strokes in patients with postoperative AF at
 2327 high stroke risk,^{368, 386} and to assess whether short episodes of postoperative AF (e.g. < 48 h) carry a similar risk
 2328 as longer episodes.⁹⁶⁰ The indication and timing of OAC in postoperative AF patients should take into
 2329 consideration the risk of postoperative bleeding.
 2330

2331 13.5.3. Rhythm control therapy in postoperative atrial fibrillation

2332 In haemodynamically unstable patients, cardioversion and consideration of antiarrhythmic drugs is
 2333 recommended. Amiodarone or vernakalant have been efficient in converting postoperative AF to sinus
 2334 rhythm.^{603, 950, 961} A recent medium-sized trial randomizing patients with postoperative AF to either rhythm
 2335 control therapy with amiodarone or to rate control did not find a difference in hospital admissions during a 60-
 2336 day follow-up,⁹⁶² underpinning that the aim of rhythm control therapy should be to improve AF-related
 2337 symptoms in postoperative AF. In asymptomatic patients and in those with acceptable symptoms, rate control or
 2338 deferred cardioversion preceded by anticoagulation is a reasonable approach.
 2339

2340 Recommendations for preventing postoperative AF

Recommendations	Class ^a	Level ^b	Refs ^c
Perioperative oral beta-blocker therapy is recommended for the prevention of postoperative AF after cardiac surgery	I	B	925, 928
Restoration of sinus rhythm by electrical cardioversion or antiarrhythmic drugs is recommended in postoperative AF with haemodynamic instability	I	C	
Long-term anticoagulation should be considered in patients with AF after cardiac surgery at risk for stroke, considering individual stroke and bleeding risk	IIa	B	368, 386
Antiarrhythmic drugs should be considered for recurrent or symptomatic postoperative AF after cardiac surgery in an attempt to restore sinus rhythm	IIa	C	
Perioperative amiodarone should be considered for prophylactic therapy to prevent AF after cardiac surgery	IIa	A	925
Intravenous vernakalant may be considered for cardioversion of postoperative AF in patients without severe heart failure, hypotension, or severe structural heart disease (especially aortic stenosis)	IIb	B	603
Asymptomatic postoperative AF should initially be managed with rate control and anticoagulation	IIa	B	962

2341 AF = atrial fibrillation.

2342 ^aClass of recommendation.

2343 ^bLevel of evidence.

2344 ^cReference(s) supporting recommendations.

2345

2346 13.6. Atrial arrhythmias in grown-up patients with congenital heart disease

2347 Atrial arrhythmias (AF, atrial flutter, atrial tachycardias) often occur late after surgical repair of congenital heart
 2348 defects, occurring in 15–40% of grown-up patients with congenital heart disease (GUCH). They are associated
 2349 with heart failure, syncope, thromboembolic events, and sudden death.⁹⁶³⁻⁹⁶⁷ The pathophysiological substrate is
 2350 complex, associated with hypertrophy, fibrosis, hypoxaemia, chronic haemodynamic overload, and surgical
 2351 scars and patches. Additionally, related primary anomalies in the conduction pathways can lead to reentrant
 2352 atrial and ventricular tachycardia, heart block, and sinus node dysfunction.⁹⁶³ Macro-reentrant atrial tachycardia
 2353 or atypical atrial flutter may be seen after nearly any surgical procedure involving atriotomy or atrial patches.
 2354

2355 **13.6.1. General management of atrial arrhythmias in grown-up patients with** 2356 **congenital heart disease**

2357 The conventional stroke risk factors should be used to inform decisions on long-term anticoagulation in GUCH
 2358 patients with AF. In addition, anticoagulation should be considered in GUCH patients with atrial arrhythmias
 2359 when they present with intracardial repair, cyanosis, Fontan palliation, or systemic right ventricle, in addition to
 2360 those with conventional stroke risk factors.⁹⁶⁸ Beta-blockers, verapamil, diltiazem, and digitalis can be used.
 2361 Care should be taken to avoid bradycardia and hypotension.

2362 Sodium channel blockers suppress approximately half of atrial arrhythmias in Fontan patients.⁹⁶⁹
 2363 Amiodarone is more effective, but long-term treatment with an antiarrhythmic drugs carries a high risk of
 2364 extracardiac side-effects in this relatively young population. Intracardiac thrombi are common in GUCH
 2365 patients undergoing cardioversion for AF, but also in patients with atrial tachycardias or atrial flutter.⁹⁷⁰
 2366 Therefore, both a TOE and anticoagulation for a few weeks before the planned cardioversion should be
 2367 considered.⁹⁶⁴ Radiofrequency ablation may be a good option for symptomatic GUCH patients with atrial
 2368 arrhythmias, especially in those with atrial flutter and other macro-reentrant tachycardias. Interventions should
 2369 be performed in adequately qualified centres by specialized teams.
 2370

2371 **13.6.2. Atrial tachyarrhythmias and atrial septal defects**

2372 Atrial flutter and fibrillation occur in 14–22% of adults with unoperated atrial septal defects, especially in older
 2373 patients,⁹⁷¹ and can lead to heart failure.⁹⁷² Early repair can reduce but not eliminate the risk of AF.⁹⁷³ Batrial
 2374 volume overload,⁹⁷⁴ pulmonary hypertension,⁹⁷⁵ and possibly the arrhythmogenic effect of atrial patches can
 2375 contribute to these arrhythmias.⁹⁷⁶ Anticoagulation should be decided based on stroke risk factors. In patients
 2376 with a history of paroxysmal or persistent AF, AF surgery could be considered at the time of surgical closure, or
 2377 catheter ablation in patients undergoing interventional atrial septal defect closure. Catheter ablation of late atrial
 2378 arrhythmias has shown to be effective in 46 consecutive patients after surgical atrial septal defect.⁹⁷⁷
 2379

2380 **13.6.3. Atrial tachyarrhythmias after Fontan operation**

2381 Atrial arrhythmias occur in up to 40% of patients with a Fontan circulation, and can manifest as atrial flutter,
 2382 primary atrial tachycardia, AF, and accelerated junctional rhythm or junctional tachycardia⁹⁷⁸ with or without
 2383 sinoatrial node dysfunction.⁹⁷⁹ Patients with atriopulmonary anastomoses (possibly due to higher atrial volume
 2384 and pressure load) and those with early postoperative atrial arrhythmias are more likely to develop long-term
 2385 atrial arrhythmias.⁹⁸⁰ Atrial arrhythmias can also be the first manifestation of obstruction of the atriopulmonary
 2386 anastomosis, a complication that must be identified. Right atrial thrombus formation is common in Fontan
 2387 patients with atrial arrhythmias and requires oral anticoagulation.⁹⁸¹ Operative conversion to total
 2388 cavopulmonary artery connection with concomitant arrhythmia surgery can in some patients improve heart
 2389 failure symptoms and reduce recurrent arrhythmias,^{969, 982} with low recurrence rates of clinically apparent atrial
 2390 arrhythmias in the first few years after repeat surgery.⁹⁸³⁻⁹⁸⁵ Catheter ablation of atrial arrhythmia in Fontan
 2391 patients has been successful in selected patients.⁹⁸⁶
 2392

2393 **13.6.4. Atrial tachyarrhythmias after tetralogy of Fallot correction**

2394 Approximately one-third of patients after repair of tetralogy of Fallot develop atrial arrhythmias, including intra-
 2395 atrial reentrant tachycardia, focal atrial tachycardia, and AF.⁹⁸⁷ Circuits involving the cavotricuspid isthmus and
 2396 areas of presumed surgical right atrial scarring have been described as responsible for atrial arrhythmias.
 2397

2398 **Recommendations in patients with GUCH**

Recommendations	Class ^a	Level ^b	Refs ^c
Atrial septal defect closure should be considered before the fourth decade of life to diminish the chance of atrial flutter and fibrillation	Ila	C	971, 972, 974

In patients who need surgical closure of an atrial septal defect and who have a history of symptomatic atrial arrhythmia, atrial ablation should be considered at the time of surgical closure	IIa	C	204, 988, 989
Cox maze surgery should be considered in patients with symptomatic AF and an indication for corrective repair of congenital heart defects. All such surgery should be done in experienced centres	IIa	C	988, 990
Oral anticoagulation should be considered in all adult patients with intracardiac repair, cyanosis, Fontan palliation, or systemic right ventricle and a history of AF, atrial flutter, or intra-atrial reentrant tachycardia. In all other congenital heart disease patients with AF, anticoagulation should be considered if the CHA ₂ DS ₂ -VAS _C score is ≥ 1	IIa	C	968
Catheter ablation of atrial arrhythmias associated with congenital heart defects may be considered when performed in experienced centres	IIb	C	991
In patients with congenital heart disease, transoesophageal echocardiography may be considered together with 3-week anticoagulation therapy before cardioversion	IIb	C	964, 970, 988, 990

2399 AF = atrial fibrillation; CHA₂DS₂-VASc = Congestive Heart failure, hypertension, Age ≥ 75 (doubled),
 2400 Diabetes, Stroke (doubled), Vascular disease, Age 65–74, and Sex (female); GUCH = grown-up patients with
 2401 congenital heart disease; OAC = oral anticoagulation; TOE = transoesophageal echocardiography.

2402 ^aClass of recommendation.

2403 ^bLevel of evidence.

2404 ^cReference(s) supporting recommendations.

2405

2406 13.7. Management of atrial flutter

2407 The goals for the management of atrial flutter are similar to those for AF.⁹⁹² Based on the available evidence, the
 2408 stroke risk in patients with atrial flutter is not much different from that in AF.⁸²⁷ Furthermore, many patients
 2409 diagnosed with atrial flutter develop AF.⁹⁹³⁻⁹⁹⁵ Thus, anticoagulation should be used in patients with atrial flutter
 2410 similar to that in patients with AF. Rate control in atrial flutter is achieved with the same medications as in AF,
 2411 but is often more difficult to achieve. Flecainide, propafenone, dofetilide, and intravenous ibutilide are useful for
 2412 cardioversion of atrial flutter. They should be combined with a rate-controlling agent to avoid 1:1 conduction of
 2413 slowing flutter waves to the ventricles. Ibutilide is more effective for conversion of atrial flutter than AF,
 2414 whereas vernakalant is less effective in converting typical atrial flutter.^{996, 997} Electrical cardioversion of atrial
 2415 flutter can be performed using lower energies (50–100 J) than for AF.^{998, 999} Atrial overdrive pacing through
 2416 pacemaker leads or endocardial or transesophageal catheters can convert atrial flutter to sinus rhythm.^{1000, 1001}
 2417 Anticoagulation and transoesophageal echocardiography around cardioversion or overdrive pacing should be
 2418 used similar to that in AF.

2419 Ablation of the cavotricuspid isthmus for isthmus-dependent right atrial flutter (either the common
 2420 counter-clockwise atrial flutter or the less-common clockwise atrial flutter) restores and maintains sinus rhythm
 2421 with a success rate of 90–95%.¹⁰⁰² It may also reduce AF recurrences in selected patients,^{1003, 1004} and help to
 2422 prevent hospitalizations.^{1004, 1005} Isthmus ablation is comparably safe and more effective than antiarrhythmic
 2423 drug therapy, and is recommended for recurrent atrial flutter.^{585-587, 713} Catheter ablation of left atrial macro-
 2424 reentrant tachycardia is more complex, with lower success rates and higher recurrence rates.^{1006, 1007}

2425

2426 Recommendations for management of atrial flutter

Recommendations	Class ^a	Level ^b	Refs ^c
For patients with atrial flutter, antithrombotic therapy is recommended according to the same risk profile used for AF	I	B	827
Overdrive atrial pacing of atrial flutter should be considered as an alternative to electrical cardioversion, depending on local availability and experience	IIa	B	1000, 1001

Management of typical atrial flutter with ablation of the cavotricuspid isthmus is recommended for patients failing antiarrhythmic drug therapy or as first-line treatment considering patient preference	I	B	158
If atrial flutter has been documented before AF ablation, ablation of the cavotricuspid isthmus should be considered as part of the AF ablation procedure	IIa	C	

2427 AF = atrial fibrillation.

2428 ^aClass of recommendation.

2429 ^bLevel of evidence.

2430 ^cReference(s) supporting recommendations.

2431

2432 **14 Patient involvement, education and self-management**

2433 A fundamental aspect of a structured AF management programme is the focus on patient-centred care.

2434

2435 **14.1. Patient-centred care**

2436 Autonomous, informed patients are better placed to adhere to long-term therapy, and it is very likely that long-term management of chronic conditions such as AF will benefit from informed patients involved in the disease management who are aware of their own responsibilities.³²⁸ Shared decision-making⁷⁴⁷ and patient-centred organization of care can help to ensure adherence to management and empower patients, and respect individual patient preferences, needs, and values (see Chapter 7.2).^{326, 1008, 1009} Patients in an active role tend to have better health outcomes and care experiences, and engagement itself can be considered as an intermediate outcome, particularly where related to improved clinical outcomes.¹⁰¹⁰

2441

2442

2443

2444 **14.2. Integrated patient education**

2445 Education is a prerequisite for informed, involved patients and patient-centred care. However, lack of AF-related knowledge in patients is common, even in those who have received verbal and written information,^{32, 1011, 1012} indicating the need to further develop structured patient education. Several patient-information tools have been developed, largely focusing on oral anticoagulation.¹⁰¹³⁻¹⁰¹⁶ Understanding patients' perceptions and attitudes towards AF and its management can improve AF management and related outcomes.¹⁰¹⁷ This includes tailored patient education focusing on the disease, symptom recognition, therapy, modifiable risk factors for AF, and self-management activities.^{1018, 1019}

2451

2452

2453 **14.3. Self-management and shared decision-making**

2454 Self-management is primarily focused on tasks to manage the condition, such as adhering to a therapeutic regimen or modifying behaviour (e.g. resulting in smoking cessation or weight loss).¹⁰²⁰ It requires understanding of the treatment modalities and goals.³⁵⁰ Within a multidisciplinary team, allied health professionals can guide this interactive process in which communication, trust, and reciprocal respect foster patient engagement.¹⁰²¹ Shared decision-making should be considered as a routine part of the decision-making process,⁷⁴⁷ supported by decision aids where applicable.¹⁰²² Models of care that integrate education, engagement, and shared decision making are now available,¹⁰²³ and may be of particular value in the management of AF.

2461

2462

2463

Recommendations for patient involvement, education, and self-management

Recommendations	Class ^a	Level ^b	Refs ^c
Tailored patient education is recommended in all phases of AF management to support patients' perception of AF and to improve management	I	C	1014, 1017
Patient involvement in the care process should be considered to encourage self-management and responsibility for lifestyle changes	IIa	C	328, 1010
Shared decision-making should be considered to ensure that care is based on the best available evidence and fits the needs, values, and preferences of the patient	IIa	C	747

2464 AF = atrial fibrillation.

2465 ^aClass of recommendation.

2466 ^bLevel of evidence.

2467 ^cReference(s) supporting recommendations.

2468

2469 **15 Gaps in evidence**

2470 There are some areas of AF management that are supported by excellent evidence from multiple, adequately
2471 powered randomized trials (e.g. oral anticoagulation. Other areas, such as rhythm control therapy, integrated AF
2472 management, and lifestyle modifications are clearly developing the required evidence, while areas such as rate
2473 control are in dire need of better studies to underpin future guidelines. Here we identify areas in need of further
2474 research.

2475

2476 **15.1. Major health modifiers causing atrial fibrillation**

2477 Atrial fibrillation has different causes in different patients. More research is needed into the major causes (and
2478 electrophysiological mechanisms) of AF in different patient groups.^{176, 1024} Such research should consider the
2479 major comorbidities associated with AF, and characterize the response to AF therapy in patients with different,
2480 pathophysiologically distinct types of AF.

2481

2482 **15.2. How much atrial fibrillation constitutes a mandate for therapy?**

2483 Technological advances allow screening for an irregular pulse using patient-operated ECG devices,
2484 smartphones, and a variety of other technologies. These may be very useful to detect silent, undiagnosed AF.¹⁵⁷
2485 Adequately powered studies evaluating the diagnostic accuracy of such technologies, the diagnostic yield in
2486 different populations, the shortest duration of atrial arrhythmias conveying a stroke risk, and ideally the effect of
2487 ECG screening on outcomes are needed.

2488

2489 **15.3. Atrial high-rate episodes and need for anticoagulation**

2490 All of the information on the benefit of OAC has been in patients with AF diagnosed by ECG. Technological
2491 advances allow ready detection of AHRE in patients with implanted devices and an atrial lead. Such patients are
2492 at increased stroke risk, but it is unclear whether they benefit from OAC. Controlled trials evaluating OAC in
2493 AHRE patients are ongoing and will provide evidence on the best antithrombotic therapy in these patients.

2494

2495 **15.4. Stroke risk in specific populations**

2496 Several specific AF groups should be studied to better characterize their risk for AF, stroke, and other AF-
2497 related complications (e.g. patients with one stroke risk factor, and non-Caucasian patients). Confounding
2498 factors (e.g. different therapy of concomitant cardiovascular diseases) may help to explain the variability in the
2499 reported rates of incident AF, prevalent AF, and AF complications. This also applies to the effect of gender in
2500 AF patients.⁴⁷

2501

2502 **15.5. Anticoagulation in patients with severe chronic kidney disease**

2503 The use of NOACs has not been tested in patients with creatinine clearance < 30 mL/min, and there is very little
2504 evidence on the effects of OAC in patients on haemodialysis or on other forms of renal-replacement therapy.
2505 Studies evaluating OAC in patients with severe chronic kidney disease are needed to inform the best
2506 management in this patient group at high risk for stroke and bleeding.

2507

2508 **15.6. Left atrial appendage occlusion for stroke prevention**

2509 The most common justification for LAA occlusion devices in clinical practice is a perceived high bleeding risk
2510 and, less often, contraindications for OAC.⁴⁵⁹ Unfortunately, LAA occluders have not been tested in such
2511 populations. Furthermore, LAA occluders have not been compared with NOAC therapy in patients at risk for
2512 bleeding, or with thoracoscopic LAA clipping. There is a clear need to conduct adequately designed and
2513 powered trials to define the clinical role of LAA occluders compared with NOAC therapy in patients with
2514 relative or absolute contraindications for anticoagulation, and/or in those suffering from an ischaemic stroke on
2515 anticoagulant therapy.

2516

2517 **15.7. Anticoagulation in atrial fibrillation patients after a bleeding or stroke event**

2518 At least 2% of anticoagulated patients with AF will experience a serious bleeding event per year. Observational
2519 data suggest that OAC can be reinitiated even after an intracerebral bleeding event.^{460, 484} Controlled studies
2520 evaluating different anticoagulation and stroke prevention interventions are urgently needed to provide evidence
2521 on the best management of patients who have suffered a bleeding event that would usually lead to withholding

2522 OAC. Some studies (e.g. APACHE II¹⁰²⁵) are ongoing, but adequately powered trials are needed. Similarly,
2523 prospectively collected data are needed on the efficacy and bleeding risk following (re-)initiation of OAC after
2524 stroke or intracranial bleeding.
2525

2526 **15.8. Anticoagulation and optimal timing of non-acute cardioversion**

2527 Based on retrospective data, previous recommendations on the safe time-window in which a cardioversion can
2528 be performed in new-onset AF used ≤ 48 hours as the ‘gold standard’ for non-protected cardioversion. However,
2529 new evidence has emerged that initiating precardioversion anticoagulation in patients with AF episodes of < 24
2530 hours or even < 12 hours would provide even better safety.^{642, 647, 1026-1028} Further research is needed to establish
2531 a clear safety margin in this clinical situation.
2532

2533 **15.9. Competing causes of stroke or transient ischaemic attack in atrial fibrillation** 2534 **patients**

2535 Prospective RCTs have demonstrated the superiority of carotid endarterectomy compared to stenting in patients
2536 with symptomatic high-degree stenosis of the internal carotid artery.¹⁰²⁹ As endarterectomy minimizes the need
2537 for combination therapy with OAC and antiplatelets,¹⁰³⁰ this approach has appeal in patients with AF to reduce
2538 bleeding risk. However, few of these studies included patients with AF. In a large observational study, the
2539 composite of in-hospital mortality, post-procedural stroke, and cardiac complications was higher in AF patients
2540 undergoing carotid stenting (457/7668; 6.0%) compared with endarterectomy (4438/51320; 8.6%; $P <$
2541 0.0001).¹⁰³¹ Despite adjustment for baseline risk, this may just reflect the type of patients referred for each
2542 procedure, and further randomized studies are needed to confirm the optimal treatment strategy in AF patients
2543 with carotid disease.
2544

2545 **15.10. Anticoagulation in patients with biological heart valves (including transcatheter** 2546 **aortic valve implantation) and non-rheumatic valve disease**

2547 The optimal antithrombotic therapy in the first months after biological valve replacement (including after
2548 catheter-based valve replacement) is not known. VKAs remain the mainstay during the initial postoperative
2549 period; NOACs probably deliver the same protection. In patients without AF, many centres use platelet
2550 inhibitors only. NOACs appear to be equally effective as VKAs in patients with moderate aortic stenosis, based
2551 on a subanalysis from the ROCKET-AF (Rivaroxaban Once Daily Oral Direct Factor Xa Inhibition Compared
2552 with Vitamin K Antagonism for Prevention of Stroke and Embolism Trial in Atrial Fibrillation) trial¹⁰³² as well
2553 as the Loire Valley AF project.¹⁰³³ Further data would be helpful to confirm these observations.¹⁰³⁴ The safety
2554 and efficacy of NOACs in patients with rheumatic mitral valve disease has not been evaluated and should be
2555 studied.
2556

2557 **15.11. Anticoagulation after ‘successful’ catheter ablation**

2558 In view of the long-term recurrence rates of AF, this Task Force recommends to continue OAC in AF patients
2559 after ‘successful’ catheter ablation. Nonetheless, observational data suggest that the stroke risk may be lower
2560 after catheter ablation of AF compared with other AF patients. The ongoing EAST (Early treatment of Atrial
2561 fibrillation for Stroke prevention Trial) trial will inform in a more general way whether rhythm control therapy
2562 can reduce stroke rates in anticoagulated AF patients. If confirmed, there may be a place for a controlled trial
2563 evaluating the termination of OAC therapy at an interval after ‘successful’ catheter ablation.
2564

2565 **15.12. Comparison of rate control agents**

2566 Although the use of rate control therapy is very common in AF patients, robust data comparing rate control
2567 therapies are scant, with the majority of studies being small uncontrolled trials over short periods of follow-up.
2568 Some studies are funded (e.g. RATE-AF [Rate Control Therapy Evaluation in Permanent Atrial Fibrillation]⁵⁵⁹)
2569 and will investigate the potential benefits of different rate controlling agents, characteristics, or biomarkers that
2570 can help to personalize the use of rate control, and the adverse-event profile of specific drugs in defined groups
2571 of patients (e.g. AF with HFrEF).
2572

2573 **15.13. Catheter ablation in persistent and long-standing persistent AF**

2574 While a few recent randomized studies support the use of catheter or surgical ablation in patients with persistent
2575 AF and long-standing persistent AF, there is a clear need for more data evaluating this intervention in
2576 adequately powered randomized trials.

2577

2578 15.14. Optimal technique for repeat catheter ablation

2579 PVI emerges as the most important target for catheter ablation of AF. Although a plethora of different additional
2580 ablation techniques have been published, their added value is questionable in patients undergoing a first catheter
2581 ablation, including those with persistent AF.⁷³⁵ Many patients are in need of multiple catheter-ablation
2582 procedures, and such interventions often follow local or operator-specific protocols without clear evidence to
2583 support the choice of ablation target or intervention. There is a clear clinical need to define the best approach in
2584 patients who are in need of a second ablation procedure.
2585

2586 15.15. Combination therapy for maintenance of sinus rhythm

2587 In the follow-up after initially successful catheter ablation, even when done in experienced centres, many
2588 patients will experience symptomatic recurrences of AF. These patients are often managed with antiarrhythmic
2589 drugs. There is a surprising paucity of data evaluating different rhythm control interventions in patients with
2590 recurrent AF after catheter ablation. Such studies seem reasonable and feasible.
2591

2592 15.16. Can rhythm control therapy convey a prognostic benefit in atrial fibrillation patients?

2593 The progress in rhythm control therapy (catheter ablation, new antiarrhythmic drugs) and observational long-
2594 term analyses suggest that rhythm control therapy may have a prognostic benefit. Ongoing trials such as
2595 CABANA and EAST – AFNET 4 will provide initial answers to this important question, but more data are
2596 needed, in addition to trials of surgical ablation techniques.
2597
2598

2599 15.17. Thoracoscopic ‘stand-alone’ atrial fibrillation surgery

2600 Minimally invasive epicardial ablation surgery for the treatment of stand-alone AF was reported a decade
2601 ago.¹⁰³⁵ The procedure has since evolved towards a totally thoracoscopic procedure,¹⁰³⁶ and lesion sets were
2602 extended to a complete left atrial maze.⁸²² With such rapid development and the coexistence of different
2603 techniques and lesion sets, scientific evidence on long-term results is still limited. Randomized trials using a
2604 standardized procedure are urgently needed to clearly define the benefits and risks of thoracoscopic AF ablation,
2605 and to further support decisions of the AF Heart Team.
2606

2607 15.18. Surgical exclusion of the left atrial appendage

2608 Exclusion of the LAA has been performed by cardiothoracic surgeons for decades, but prospective randomized
2609 studies comparing the rate of ischaemic stroke with or without left appendage exclusion are presently lacking.
2610 The LAAOS (Left Atrial Appendage Occlusion Study) III is currently randomizing cardiac surgery patients with
2611 AF to undergo concomitant occlusion or no occlusion of the appendage.⁴⁶⁷ More data are also needed to confirm
2612 the safety and efficacy of thoracoscopic exclusion, following early positive observational data.¹⁰³⁷
2613

2614 15.19. Concomitant atrial fibrillation surgery

2615 Adequately powered randomized trials are needed, employing systematic follow-up, uniform lesion sets and
2616 energy sources to evaluate the benefits and risks of concomitant AF surgery in symptomatic AF patients. An
2617 RCT on non-uniform lesion sets with long-term follow-up is due to publish shortly.¹⁰³⁸ These will assist the AF
2618 Heart Team to decide on optimal therapy for individual patients, including the full repertoire of medical and
2619 surgical options for the treatment of AF.
2620

2621 **16 To do and not to do messages from the Guidelines**

2622

Recommendations for diagnosis and screening of AF	Class	Level
ECG documentation is required to establish the diagnosis of AF	I	B
Opportunistic screening for AF is recommended by pulse taking or ECG rhythm strip in patients > 65 years of age	I	B
In patients with TIA or ischaemic stroke, screening for AF is recommended by short-term ECG recording followed by continuous ECG monitoring for at least 72 hours	I	B
It is recommended to interrogate pacemakers and ICDs on a regular basis for atrial high rate episodes (AHRE). Patients with AHRE should undergo further ECG monitoring to document AF before initiating AF therapy	I	B
Recommendations for general management of AF	Class	Level
Tailored patient education is recommended in all phases of AF management to support patients' perception of AF and to improve management	I	C
A full cardiovascular evaluation, including an accurate history, careful clinical examination, and assessment of concomitant conditions, is recommended in all AF patients	I	C
Use of the modified EHRA symptom scale is recommended in clinical practice and research studies to quantify AF-related symptoms	I	C
Transthoracic echocardiography is recommended in all AF patients to guide management	I	C
The assessment of kidney function by serum creatinine or creatinine clearance is recommended in all AF patients to detect kidney disease and to support correct dosing of AF therapy	I	A
Recommendations for stroke prevention in AF	Class	Level
The CHA ₂ DS ₂ -VASc score is recommended for stroke risk prediction in patients with AF	I	A
Oral anticoagulation therapy to prevent thromboembolism is recommended for all male AF patients with a CHA ₂ DS ₂ -VASc score of 2 or more	I	A
Oral anticoagulation therapy to prevent thromboembolism is recommended in all female AF patients with a CHA ₂ DS ₂ -VASc score of 3 or more	I	A
When oral anticoagulation is initiated in a patient with AF who is eligible for a non vitamin-K-antagonist oral anticoagulant (NOAC, apixaban, dabigatran, edoxaban, or rivaroxaban), a NOAC is recommended in preference to a Vitamin K antagonist	I	A
Vitamin K antagonist therapy (INR 2.0–3.0 or higher) is recommended for stroke prevention in AF patients with moderate-to-severe mitral stenosis or mechanical heart valves	I	B
NOACs (apixaban, dabigatran, edoxaban, and rivaroxaban) are not recommended in patients with mechanical heart valves (Level of evidence B) or moderate-to-severe mitral stenosis (Level of evidence C)	III (harm)	B/C
When patients are treated with a vitamin K antagonist, time in therapeutic range (TTR) should be kept as high as possible and closely monitored	I	A
Combinations of oral anticoagulants and platelet inhibitors increase bleeding risk and should be avoided in AF patients without another indication for platelet	III (harm)	B

inhibition		
In male or female AF patients without additional stroke risk factors, anticoagulant or antiplatelet therapy is not recommended for stroke prevention	III (harm)	B
Antiplatelet monotherapy is not recommended for stroke prevention in AF patients, regardless of stroke risk	III (harm)	A
After surgical occlusion or exclusion of the left atrial appendage, it is recommended to continue anticoagulation in at-risk patients with AF for stroke prevention	I	B
Genetic testing before the initiation of vitamin K antagonist therapy is not recommended.	III (no benefit)	B
In AF patients with severe active bleeding events, it is recommended to interrupt oral anticoagulation therapy until the underlying cause is resolved	I	C
NOACs should be avoided in pregnancy and in women planning a pregnancy	III (harm)	C
For patients with atrial flutter, antithrombotic therapy is recommended according to the same risk profile used for AF	I	B
Management of typical atrial flutter with ablation of the cavotricuspid isthmus is recommended for patients failing antiarrhythmic drug therapy or as first-line treatment considering patient preference	I	B
Lifelong oral anticoagulation to prevent stroke is recommended in hypertrophic cardiomyopathy patients who develop AF	I	B
Anticoagulation with heparin or low-molecular-weight heparin immediately after ischaemic stroke is not recommended in AF patients	III (harm)	A
Systemic thrombolysis with a recombinant tissue plasminogen activator is not recommended if the INR is above 1.7 (or, for patients on dabigatran, if activated partial thromboplastin time is outside the normal range)	III (harm)	C
After TIA or stroke, combination therapy of OAC and an antiplatelet is not recommended	III (harm)	B
Recommendations for rate control of AF	Class	Level
Beta-blocker, digoxin, diltiazem, or verapamil is recommended to control heart rate in AF patients with LVEF \geq 40%	I	B
Beta-blocker and/or digoxin is recommended to control heart rate in AF patients with LVEF < 40%	I	B
In patients with permanent AF (i.e. where no attempt to restore sinus rhythm is planned), antiarrhythmic drugs should not routinely be used for rate control	III (harm)	A
Recommendations for rhythm control of AF	Class	Level
Rhythm control therapy is indicated for symptom improvement in patients with AF	I	B
Cardioversion of AF (either electrical or pharmacological) is recommended in symptomatic patients with persistent or long-standing persistent AF as part of rhythm control therapy	I	B
In patients with no history of ischaemic or structural heart disease, flecainide, propafenone, or vernakalant is recommended for pharmacological cardioversion of new-onset AF	I	A

In patients with ischaemic and/or structural heart disease, amiodarone is recommended for cardioversion of AF	I	A
For cardioversion of AF/atrial flutter, effective anticoagulation is recommended for a minimum of 3 weeks before cardioversion	I	B
Transoesophageal echocardiography (TOE) is recommended to exclude cardiac thrombus, as an alternative to preprocedural anticoagulation when early cardioversion is planned	I	B
The choice of antiarrhythmic drug needs to be carefully evaluated, taking into account the presence of comorbidities, cardiovascular risk and potential for serious proarrhythmia, extracardiac toxic effects, patient preferences, and symptom burden	I	A
Dronedarone, flecainide, propafenone, or sotalol is recommended for prevention of recurrent symptomatic AF in patients with normal left ventricular function and without pathological left ventricular hypertrophy.	I	A
Dronedarone is recommended for prevention of recurrent symptomatic AF in patients with stable coronary artery disease, and without heart failure	I	A
Amiodarone is recommended for prevention of recurrent symptomatic AF in patients with heart failure	I	B
Antiarrhythmic drug therapy is not recommended in patients with prolonged QT interval (> 0.5 s) or with significant sinoatrial node disease or atrioventricular node dysfunction who do not have a functioning permanent pacemaker	III (harm)	C
Catheter ablation of symptomatic paroxysmal AF is recommended to improve AF symptoms in patients who have symptomatic recurrences of AF on antiarrhythmic drug therapy (amiodarone, dronedarone, flecainide, propafenone, sotalol) and who prefer further rhythm control therapy, when performed by an electrophysiologist who has received appropriate training and is performing the procedure in an experienced centre	I	A
ARBs or ACE inhibitors are not recommended for the secondary prevention of paroxysmal AF in patients with little or no underlying heart disease.	III (no benefit)	B
Moderate regular physical activity is recommended to prevent AF, while athletes should be counselled that long-lasting, more intense sports participation can promote AF	I	A

2623
2624
2625

2626 17 A short summary of the management of AF patients

2627

2628 Here, we provide 17 simple rules to guide diagnosis and management of AF patients according to the 2016
2629 ESC/EACTS/ESO Guidelines for the management of atrial fibrillation

2630

2631 1. Use ECG screening in at risk populations for atrial fibrillation, especially stroke survivors and the
2632 Elderly.

2633

2. Document AF by ECG before starting treatment.

2634

2635 3. Evaluate all AF patients by clinical evaluation, ECG, and echocardiogram for underlying
cardiovascular conditions such as hypertension, heart failure, valvular heart disease, and others.

2636

2637 4. Provide tailored information and education to AF patients to empower them to support AF
management.

2638

5. Propose life style changes to all suitable AF patients to make their management more effective.

2639

2640 6. Treat underlying cardiovascular conditions adequately, e.g. valve repair or replacement in AF patients
2641 with significant valvular heart disease, treatment of heart failure, or management of hypertension,
among others.

2642

2643 7. Use oral anticoagulation in all AF patients unless they are at low risk for stroke based on the
CHA₂DS₂VASc score or have true contraindications for anticoagulant therapy.

2644

2645 8. Anticoagulate patients with atrial flutter similar to atrial fibrillation. Offer isthmus ablation to
symptomatic flutter patients.

2646

2647 9. Reduce all modifiable bleeding risk factors in all AF patients on oral anticoagulation, e.g. by treating
2648 hypertension, minimising the duration and intensity of concomitant antiplatelet and NSAID therapy ,
2649 treating anaemia and eliminating causes for blood loss, maintaining stable INR values in patients on
vitamin K antagonists, and moderating alcohol intake

2650

2651 10. Check ventricular rate in all AF patients and use rate control medications to achieve lenient rate
control.

2652

2653 11. Evaluate AF-related symptoms in all AF patients using the modified EHRA score. Whenever patients
2654 have AF-related symptoms, aim to improve symptoms by adjustment of rate control therapy and by
offering antiarrhythmic drugs, cardioversion, or catheter or surgical ablation.

2655

2656 12. Select antiarrhythmic drugs based on their safety profile and consider catheter or surgical ablation
when antiarrhythmic drugs fail.

2657

2658 13. Do not offer routine genetic testing in AF patients unless there is a suspicion for an inherited cardiac
condition.

2659

14. Do not use antiplatelet therapy for stroke prevention in AF.

2660

2661 15. Do not permanently discontinue oral anticoagulation in AF patients at increased risk of stroke unless
such a decision is taken by a multidisciplinary team.

2662

2663 16. Do neither use rhythm control therapy in asymptomatic AF patients, nor in patients with permanent
AF.

2664

2665 17. Do not perform cardioversion or catheter ablation without anticoagulation unless an atrial thrombus has
been ruled out by transesophageal echocardiogram.

2666

2667

2668

2669 18 Web Addenda

2670 All Web figures and Web tables are available in the Web addenda, available at European Heart Journal online
2671 and also via the ESC Website (www.escardio.org/guidelines).

2672

2673 19 Appendix

2674 **ESC Committee for Practice Guidelines (CPG):** Jose Luis Zamorano (Chairperson) (Spain), Victor Aboyans
2675 (France), Stephan Achenbach (Germany), Stefan Agewall (Norway), Lina Badimon (Spain), Gonzalo Barón-
2676 Esquivias (Spain), Helmut Baumgartner (Germany), Jeroen J. Bax (The Netherlands), Héctor Bueno (Spain),
2677 Scipione Carerj (Italy), Veronica Dean (France), Çetin Erol (Turkey), Donna Fitzsimons (UK), Oliver
2678 Gaemperli (Switzerland), Paulus Kirchhof (UK/Germany), Philippe Kolh (Belgium), Patrizio Lancellotti
2679 (Belgium), Gregory Y. H. Lip (UK), Petros Nihoyannopoulos (UK), Massimo F. Piepoli (Italy), Piotr
2680 Ponikowski (Poland), Marco Roffi (Switzerland), Adam Torbicki (Poland), António Vaz Carneiro (Portugal),
2681 Stephan Windecker (Switzerland).

2682

2683 **ESC National Cardiac Societies** actively involved in the review process of the 2016 ESC Guidelines for the
2684 management of atrial fibrillation developed in collaboration with EACTS

2685

2686 **Armenia:** Armenian Cardiologists Association, Hamlet G. Hayrapetyan; **Austria:** Austrian Society of
2687 Cardiology, Franz Xaver Roithinger; **Azerbaijan:** Azerbaijan Society of Cardiology, Farid Aliyev; **Belarus:**
2688 Belorussian Scientific Society of Cardiologists, Alexandr Chasnoits; **Belgium:** Belgian Society of Cardiology,
2689 Georges H. Mairesse; **Bosnia and Herzegovina:** Association of Cardiologists of Bosnia and Herzegovina,
2690 Daniela Loncar Matičević; **Bulgaria:** Bulgarian Society of Cardiology, Tchavdar Shalganov; **Croatia:** Croatian
2691 Cardiac Society, Boško Skorić; **Cyprus:** Cyprus Society of Cardiology, Loizos Antoniadis; **Czech Republic:**
2692 Czech Society of Cardiology, Milos Taborsky; **Denmark:** Danish Society of Cardiology, Steen Pehrson;
2693 **Egypt:** Egyptian Society of Cardiology, Said Khaled; **Estonia:** Estonian Society of Cardiology, Priit Kampus;
2694 **Finland:** Finnish Cardiac Society, Antti Hedman; **The Former Yugoslav Republic of Macedonia:**
2695 Macedonian FYR Society of Cardiology, Lidija Poposka; **France:** French Society of Cardiology, Jean-Yves Le
2696 Heuzey; **Georgia:** Georgian Society of Cardiology, Kakhaber Estadashvili; **Germany:** German Cardiac
2697 Society, Dietmar Bänsch; **Hungary:** Hungarian Society of Cardiology, Zoltán Csanádi; **Iceland:** Icelandic
2698 Society of Cardiology, David O. Arnar; **Ireland:** Irish Cardiac Society, David Keane; **Israel:** Israel Heart
2699 Society, Roy Beinart; **Italy:** Italian Federation of Cardiology, Francesco Romeo; **Kazakhstan:** Association of
2700 Cardiologists of Kazakhstan, Kulzida Koshumbayeva; **Kosovo:** Kosovo Society of Cardiology, Gani Bajraktari;
2701 **Kyrgyzstan:** Kyrgyz Society of Cardiology, Aibek Mirrakhimov, **Latvia:** Latvian Society of Cardiology,
2702 Oskars Kalejs; **Lebanon:** Lebanese Society of Cardiology, Samer Nasr; **Lithuania:** Lithuanian Society of
2703 Cardiology, Germanas Marinskis; **Luxembourg:** Luxembourg Society of Cardiology, Carlo Dimmer; **Malta:**
2704 Maltese Cardiac Society, Mark Sammut; **Moldova:** Moldavian Society of Cardiology, Aurel Grosu; **Morocco:**
2705 Moroccan Society of Cardiology, Salima Abdelali; **The Netherlands:** Netherlands Society of Cardiology,
2706 Martin E. W. Hemels; **Norway:** Norwegian Society of Cardiology, Ole-Gunnar Anfinnsen; **Poland:** Polish
2707 Cardiac Society, Beata Średniawa; **Portugal:** Portuguese Society of Cardiology, Pedro Adragao; **Romania:**
2708 Romanian Society of Cardiology, Gheorghe-Andrei Dan; **Russian Federation:** Russian Society of Cardiology,
2709 Evgeny N. Mikhaylov; **San Marino:** San Marino Society of Cardiology, Marco Zavatta; **Serbia:** Cardiology
2710 Society of Serbia, Tatjana Potpara; **Slovakia:** Slovak Society of Cardiology, Peter Hlivak **Slovenia:** Slovenian
2711 Society of Cardiology, Igor Zupan; **Spain:** Spanish Society of Cardiology, Angel Arenal; **Sweden:** Swedish
2712 Society of Cardiology, Frieder Braunschweig; **Switzerland:** Swiss Society of Cardiology, Dipen Shah; **Tunisia:**
2713 Tunisian Society of Cardiology and Cardio-Vascular Surgery, Ag Sana Ouali; **Turkey:** Turkish Society of
2714 Cardiology, Mesut Demir; **Ukraine:** Ukrainian Association of Cardiology, Oleg Sycho; **United Kingdom:**
2715 British Cardiovascular Society, Ed Duncan.

2716

2717

2718

2719 **20 References**

2720

2721

- 2722 1. Chugh SS, Havmoeller R, Narayanan K, Singh D, Rienstra M, Benjamin EJ, Gillum RF, Kim
2723 YH, McAnulty JH, Jr., Zheng ZJ, Forouzanfar MH, Naghavi M, Mensah GA, Ezzati M, Murray CJ.
2724 Worldwide epidemiology of atrial fibrillation: a Global Burden of Disease 2010 Study. *Circulation*
2725 2014;**129**:837-847.
- 2726 2. Colilla S, Crow A, Petkun W, Singer DE, Simon T, Liu X. Estimates of current and future
2727 incidence and prevalence of atrial fibrillation in the U.S. adult population. *Am J Cardiol*
2728 2013;**112**:1142-1147.
- 2729 3. Heeringa J, van der Kuip DA, Hofman A, Kors JA, van Herpen G, Stricker BH, Stijnen T, Lip
2730 GY, Witteman JC. Prevalence, incidence and lifetime risk of atrial fibrillation: the Rotterdam study. *Eur*
2731 *Heart J* 2006;**27**:949-953.
- 2732 4. Lloyd-Jones DM, Wang TJ, Leip EP, Larson MG, Levy D, Vasan RS, D'Agostino RB, Massaro
2733 JM, Beiser A, Wolf PA, Benjamin EJ. Lifetime risk for development of atrial fibrillation: the
2734 Framingham Heart Study. *Circulation* 2004;**110**:1042-1046.
- 2735 5. Go AS, Hylek EM, Phillips KA, Chang Y, Henault LE, Selby JV, Singer DE. Prevalence of
2736 diagnosed atrial fibrillation in adults: national implications for rhythm management and stroke
2737 prevention: the AnTicoagulation and Risk Factors in Atrial Fibrillation (ATRIA) Study. *JAMA*
2738 2001;**285**:2370-2375.
- 2739 6. Krijthe BP, Kunst A, Benjamin EJ, Lip GY, Franco OH, Hofman A, Witteman JC, Stricker BH,
2740 Heeringa J. Projections on the number of individuals with atrial fibrillation in the European Union, from
2741 2000 to 2060. *Eur Heart J* 2013;**34**:2746-2751.
- 2742 7. Zoni-Berisso M, Lercari F, Carazza T, Domenicucci S. Epidemiology of atrial fibrillation:
2743 European perspective. *Clin Epidemiol* 2014;**6**:213-220.
- 2744 8. Bjorck S, Palaszewski B, Friberg L, Bergfeldt L. Atrial fibrillation, stroke risk, and warfarin
2745 therapy revisited: a population-based study. *Stroke* 2013;**44**:3103-3108.
- 2746 9. Haim M, Hoshen M, Reges O, Rabi Y, Balicer R, Leibowitz M. Prospective national study of
2747 the prevalence, incidence, management and outcome of a large contemporary cohort of patients with
2748 incident non-valvular atrial fibrillation. *J Am Heart Assoc* 2015;**4**:e001486.
- 2749 10. McManus DD, Rienstra M, Benjamin EJ. An update on the prognosis of patients with atrial
2750 fibrillation. *Circulation* 2012;**126**:e143-146.
- 2751 11. Ball J, Carrington MJ, McMurray JJ, Stewart S. Atrial fibrillation: profile and burden of an
2752 evolving epidemic in the 21st century. *Int J Cardiol* 2013;**167**:1807-1824.
- 2753 12. Kannel WB, Wolf PA, Benjamin EJ, Levy D. Prevalence, incidence, prognosis, and
2754 predisposing conditions for atrial fibrillation: population-based estimates. *Am J Cardiol* 1998;**82**:2N-
2755 9N.
- 2756 13. Nguyen TN, Hilmer SN, Cumming RG. Review of epidemiology and management of atrial
2757 fibrillation in developing countries. *Int J Cardiol* 2013;**167**:2412-2420.
- 2758 14. Oldgren J, Healey JS, Ezekowitz M, Commerford P, Avezum A, Pais P, Zhu J, Jansky P,
2759 Sigamani A, Morillo CA, Liu L, Damasceno A, Grinvalds A, Nakamya J, Reilly PA, Keltai K, Van
2760 Gelder IC, Yusufali AH, Watanabe E, Wallentin L, Connolly SJ, Yusuf S, RE-LY Atrial Fibrillation
2761 Registry Investigators. Variations in cause and management of atrial fibrillation in a prospective
2762 registry of 15,400 emergency department patients in 46 countries: the RE-LY Atrial Fibrillation
2763 Registry. *Circulation* 2014;**129**:1568-1576.
- 2764 15. Chiang CE, Naditch-Brule L, Murin J, Goethals M, Inoue H, O'Neill J, Silva-Cardoso J,
2765 Zharinov O, Gamra H, Alam S, Ponikowski P, Lewalter T, Rosenqvist M, Steg PG. Distribution and
2766 risk profile of paroxysmal, persistent, and permanent atrial fibrillation in routine clinical practice: insight
2767 from the real-life global survey evaluating patients with atrial fibrillation international registry. *Circ*
2768 *Arrhythm Electrophysiol* 2012;**5**:632-639.
- 2769 16. Wang TJ, Larson MG, Levy D, Vasan RS, Leip EP, Wolf PA, D'Agostino RB, Murabito JM,
2770 Kannel WB, Benjamin EJ. Temporal relations of atrial fibrillation and congestive heart failure and their
2771 joint influence on mortality: the Framingham Heart Study. *Circulation* 2003;**107**:2920-2925.
- 2772 17. Kishore A, Vail A, Majid A, Dawson J, Lees KR, Tyrrell PJ, Smith CJ. Detection of atrial
2773 fibrillation after ischemic stroke or transient ischemic attack: a systematic review and meta-analysis.
2774 *Stroke* 2014;**45**:520-526.
- 2775 18. Sanna T, Diener HC, Passman RS, Di Lazzaro V, Bernstein RA, Morillo CA, Rymer MM, Thijs
2776 V, Rogers T, Beckers F, Lindborg K, Brachmann J, CRYSTAL AF Investigators. Cryptogenic stroke
2777 and underlying atrial fibrillation. *N Engl J Med* 2014;**370**:2478-2486.

- 2778 19. Schnabel RB, Yin X, Gona P, Larson MG, Beiser AS, McManus DD, Newton-Cheh C, Lubitz
2779 SA, Magnani JW, Ellinor PT, Seshadri S, Wolf PA, Vasan RS, Benjamin EJ, Levy D. 50 year trends in
2780 atrial fibrillation prevalence, incidence, risk factors, and mortality in the Framingham Heart Study: a
2781 cohort study. *Lancet* 2015;**386**:154-162.
- 2782 20. Benjamin EJ, Wolf PA, D'Agostino RB, Silbershatz H, Kannel WB, Levy D. Impact of atrial
2783 fibrillation on the risk of death: the Framingham Heart Study. *Circulation* 1998;**98**:946-952.
- 2784 21. Stewart S, Hart CL, Hole DJ, McMurray JJ. A population-based study of the long-term risks
2785 associated with atrial fibrillation: 20-year follow-up of the Renfrew/Paisley study. *Am J Med*
2786 2002;**113**:359-364.
- 2787 22. Andersson T, Magnuson A, Bryngelsson IL, Frobert O, Henriksson KM, Edvardsson N, Poci
2788 D. All-cause mortality in 272,186 patients hospitalized with incident atrial fibrillation 1995-2008: a
2789 Swedish nationwide long-term case-control study. *Eur Heart J* 2013;**34**:1061-1067.
- 2790 23. Kotecha D, Holmes J, Krum H, Altman DG, Manzano L, Cleland JG, Lip GY, Coats AJ,
2791 Andersson B, Kirchhof P, von Lueder TG, Wedel H, Rosano G, Shibata MC, Rigby A, Flather MD,
2792 Beta-Blockers in Heart Failure Collaborative Group. Efficacy of beta blockers in patients with heart
2793 failure plus atrial fibrillation: an individual-patient data meta-analysis. *Lancet* 2014;**384**:2235-2243.
- 2794 24. Wolf PA, Abbott RD, Kannel WB. Atrial fibrillation as an independent risk factor for stroke: the
2795 Framingham Study. *Stroke* 1991;**22**:983-988.
- 2796 25. Krahn AD, Manfreda J, Tate RB, Mathewson FA, Cuddy TE. The natural history of atrial
2797 fibrillation: incidence, risk factors, and prognosis in the Manitoba Follow-Up Study. *Am J Med*
2798 1995;**98**:476-484.
- 2799 26. Henriksson KM, Farahmand B, Asberg S, Edvardsson N, Terent A. Comparison of
2800 cardiovascular risk factors and survival in patients with ischemic or hemorrhagic stroke. *Int J Stroke*
2801 2012;**7**:276-281.
- 2802 27. Grond M, Jauss M, Hamann G, Stark E, Veltkamp R, Nabavi D, Horn M, Weimar C,
2803 Kohrmann M, Wachter R, Rosin L, Kirchhof P. Improved detection of silent atrial fibrillation using 72-
2804 hour Holter ECG in patients with ischemic stroke: a prospective multicenter cohort study. *Stroke*
2805 2013;**44**:3357-3364.
- 2806 28. Ott A, Breteler MM, de Bruyne MC, van Harskamp F, Grobbee DE, Hofman A. Atrial
2807 fibrillation and dementia in a population-based study. The Rotterdam Study. *Stroke* 1997;**28**:316-321.
- 2808 29. Knecht S, Oelschlagel C, Duning T, Lohmann H, Albers J, Stehling C, Heindel W, Breithardt
2809 G, Berger K, Ringelstein EB, Kirchhof P, Wersching H. Atrial fibrillation in stroke-free patients is
2810 associated with memory impairment and hippocampal atrophy. *Eur Heart J* 2008;**29**:2125-2132.
- 2811 30. Ball J, Carrington MJ, Stewart S, SAFETY investigators. Mild cognitive impairment in high-risk
2812 patients with chronic atrial fibrillation: a forgotten component of clinical management? *Heart*
2813 2013;**99**:542-547.
- 2814 31. Marzona I, O'Donnell M, Teo K, Gao P, Anderson C, Bosch J, Yusuf S. Increased risk of
2815 cognitive and functional decline in patients with atrial fibrillation: results of the ONTARGET and
2816 TRANSCEND studies. *CMAJ* 2012;**184**:E329-336.
- 2817 32. Thrall G, Lane D, Carroll D, Lip GY. Quality of life in patients with atrial fibrillation: a
2818 systematic review. *Am J Med* 2006;**119**:448 e441-419.
- 2819 33. von Eisenhart Rothe A, Hutt F, Baumert J, Breithardt G, Goette A, Kirchhof P, Ladwig KH.
2820 Depressed mood amplifies heart-related symptoms in persistent and paroxysmal atrial fibrillation
2821 patients: a longitudinal analysis - data from the German Competence Network on Atrial Fibrillation.
2822 *Europace* 2015;**17**:1354-1362.
- 2823 34. Steinberg BA, Kim S, Fonarow GC, Thomas L, Ansell J, Kowey PR, Mahaffey KW, Gersh BJ,
2824 Hylek E, Naccarelli G, Go AS, Reiffel J, Chang P, Peterson ED, Piccini JP. Drivers of hospitalization
2825 for patients with atrial fibrillation: Results from the Outcomes Registry for Better Informed Treatment of
2826 Atrial Fibrillation (ORBIT-AF). *Am Heart J* 2014;**167**:735-742 e732.
- 2827 35. Kirchhof P, Schmalowsky J, Pittrow D, Rosin L, Kirch W, Wegscheider K, Meinertz T.
2828 Management of patients with atrial fibrillation by primary care physicians in Germany: 1-year results of
2829 the ATRIUM registry. *Clin Cardiol* 2014;**37**:277-284.
- 2830 36. Stewart S, Murphy N, Walker A, McGuire A, McMurray JJV. Cost of an emerging epidemic:
2831 an economic analysis of atrial fibrillation in the UK. *Heart* 2004;**90**:286-292.
- 2832 37. Kim MH, Johnston SS, Chu BC, Dalal MR, Schulman KL. Estimation of total incremental
2833 health care costs in patients with atrial fibrillation in the United States. *Circ Cardiovasc Qual*
2834 *Outcomes* 2011;**4**:313-320.
- 2835 38. Hart RG, Pearce LA, Aguilar MI. Meta-analysis: antithrombotic therapy to prevent stroke in
2836 patients who have nonvalvular atrial fibrillation. *Ann Intern Med* 2007;**146**:857-867.

- 2837 39. Ruff CT, Giugliano RP, Braunwald E, Hoffman EB, Deenadayalu N, Ezekowitz MD, Camm
2838 AJ, Weitz JI, Lewis BS, Parkhomenko A, Yamashita T, Antman EM. Comparison of the efficacy and
2839 safety of new oral anticoagulants with warfarin in patients with atrial fibrillation: a meta-analysis of
2840 randomised trials. *Lancet* 2014;**383**:955-962.
- 2841 40. Kirchhof P, Breithardt G, Camm AJ, Crijns HJ, Kuck KH, Vardas P, Wegscheider K. Improving
2842 outcomes in patients with atrial fibrillation: rationale and design of the Early treatment of Atrial
2843 fibrillation for Stroke prevention Trial. *Am Heart J* 2013;**166**:442-448.
- 2844 41. Al-Khatib SM, Allen LaPointe NM, Chatterjee R, Crowley MJ, Dupre ME, Kong DF, Lopes RD,
2845 Povsic TJ, Raju SS, Shah B, Kosinski AS, McBroom AJ, Sanders GD. Rate- and rhythm-control
2846 therapies in patients with atrial fibrillation: a systematic review. *Ann Intern Med* 2014;**160**:760-773.
- 2847 42. Lip GY, Laroche C, Ioachim PM, Rasmussen LH, Vitali-Serdoz L, Petrescu L, Darabantiu D,
2848 Crijns HJ, Kirchhof P, Vardas P, Tavazzi L, Maggioni AP, Boriani G. Prognosis and treatment of atrial
2849 fibrillation patients by European cardiologists: one year follow-up of the EURObservational Research
2850 Programme-Atrial Fibrillation General Registry Pilot Phase (EORP-AF Pilot registry). *Eur Heart J*
2851 2014;**35**:3365-3376.
- 2852 43. Marijon E, Le Heuzey JY, Connolly S, Yang S, Pogue J, Brueckmann M, Eikelboom J,
2853 Themeles E, Ezekowitz M, Wallentin L, Yusuf S, RE-LY Investigators. Causes of death and
2854 influencing factors in patients with atrial fibrillation: a competing-risk analysis from the randomized
2855 evaluation of long-term anticoagulant therapy study. *Circulation* 2013;**128**:2192-2201.
- 2856 44. Senoo K, Lip GY, Lane DA, Buller HR, Kotecha D. Residual risk of stroke and death in
2857 anticoagulated patients according to the type of atrial fibrillation: AMADEUS Trial. *Stroke*
2858 2015;**46**:2523-2528.
- 2859 45. Soliman EZ, Safford MM, Muntner P, Khodneva Y, Dawood FZ, Zakai NA, Thacker EL, Judd
2860 S, Howard VJ, Howard G, Herrington DM, Cushman M. Atrial fibrillation and the risk of myocardial
2861 infarction. *JAMA Intern Med* 2014;**174**:107-114.
- 2862 46. Emdin CA, Wong CX, Hsiao AJ, Altman DG, Peters SA, Woodward M, Odutayo AA. Atrial
2863 fibrillation as risk factor for cardiovascular disease and death in women compared with men:
2864 systematic review and meta-analysis of cohort studies. *BMJ* 2016;**532**:h7013.
- 2865 47. Ko D, Rahman F, Schnabel RB, Yin X, Benjamin EJ, Christophersen IE. Atrial fibrillation in
2866 women: epidemiology, pathophysiology, presentation, and prognosis. *Nat Rev Cardiol* 2016:[Epub
2867 ahead of print].
- 2868 48. Andersson T, Magnuson A, Bryngelsson IL, Frobert O, Henriksson KM, Edvardsson N, Poci
2869 D. Gender-related differences in risk of cardiovascular morbidity and all-cause mortality in patients
2870 hospitalized with incident atrial fibrillation without concomitant diseases: A nationwide cohort study of
2871 9519 patients. *Int J Cardiol* 2014;**177**:91-99.
- 2872 49. Fang MC, Singer DE, Chang Y, Hylek EM, Henault LE, Jensvold NG, Go AS. Gender
2873 differences in the risk of ischemic stroke and peripheral embolism in atrial fibrillation: the
2874 AnTicoagulation and Risk factors In Atrial fibrillation (ATRIA) study. *Circulation* 2005;**112**:1687-1691.
- 2875 50. Panchoy SB, Sharma PS, Panchoy DS, Patel TM, Callans DJ, Marchlinski FE. Meta-analysis
2876 of gender differences in residual stroke risk and major bleeding in patients with nonvalvular atrial
2877 fibrillation treated with oral anticoagulants. *Am J Cardiol* 2014;**113**:485-490.
- 2878 51. Potpara TS, Marinkovic JM, Polovina MM, Stankovic GR, Seferovic PM, Ostojic MC, Lip GY.
2879 Gender-related differences in presentation, treatment and long-term outcome in patients with first-
2880 diagnosed atrial fibrillation and structurally normal heart: the Belgrade atrial fibrillation study. *Int J*
2881 *Cardiol* 2012;**161**:39-44.
- 2882 52. Ball J, Carrington MJ, Wood KA, Stewart S, SAFETY Investigators. Women versus men with
2883 chronic atrial fibrillation: insights from the Standard versus Atrial Fibrillation spEcific managemenT
2884 studY (SAFETY). *PLoS One* 2013;**8**:e65795.
- 2885 53. Hughes M, Lip GY. Risk factors for anticoagulation-related bleeding complications in patients
2886 with atrial fibrillation: a systematic review. *Qjm* 2007;**100**:599-607.
- 2887 54. Roten L, Rimoldi SF, Schwick N, Sakata T, Heimgartner C, Fuhrer J, Delacretaz E, Tanner H.
2888 Gender differences in patients referred for atrial fibrillation management to a tertiary center. *Pacing*
2889 *Clin Electrophysiol* 2009;**32**:622-626.
- 2890 55. Forleo GB, Tondo C, De Luca L, Dello Russo A, Casella M, De Sanctis V, Clementi F,
2891 Fagundes RL, Leo R, Romeo F, Mantica M. Gender-related differences in catheter ablation of atrial
2892 fibrillation. *Europace* 2007;**9**:613-620.
- 2893 56. Henry L, Hunt S, Holmes SD, Martin LM, Ad N. Are there gender differences in outcomes
2894 after the Cox-Maze procedure for atrial fibrillation? *Innovations (Phila)* 2013;**8**:190-198.
- 2895 57. Michelena HI, Powell BD, Brady PA, Friedman PA, Ezekowitz MD. Gender in atrial fibrillation:
2896 Ten years later. *Gen Med* 2010;**7**:206-217.

- 2897 58. Fox CS, Parise H, D'Agostino RB, Sr., Lloyd-Jones DM, Vasan RS, Wang TJ, Levy D, Wolf
2898 PA, Benjamin EJ. Parental atrial fibrillation as a risk factor for atrial fibrillation in offspring. *JAMA*
2899 2004;**291**:2851-2855.
- 2900 59. Oyen N, Ranthe MF, Carstensen L, Boyd HA, Olesen MS, Olesen SP, Wohlfahrt J, Melbye M.
2901 Familial aggregation of lone atrial fibrillation in young persons. *J Am Coll Cardiol* 2012;**60**:917-921.
- 2902 60. Ellinor PT, Lunetta KL, Albert CM, Glazer NL, Ritchie MD, Smith AV, Arking DE, Muller-
2903 Nurasyid M, Krijthe BP, Lubitz SA, Bis JC, Chung MK, Dorr M, Ozaki K, Roberts JD, Smith JG,
2904 Pfeufer A, Sinner MF, Lohman K, Ding J, Smith NL, Smith JD, Rienstra M, Rice KM, Van Wagener
2905 DR, Magnani JW, Wakili R, Clauss S, Rotter JI, Steinbeck G, Launer LJ, Davies RW, Borkovich M,
2906 Harris TB, Lin H, Volker U, Volzke H, Milan DJ, Hofman A, Boerwinkle E, Chen LY, Soliman EZ,
2907 Voight BF, Li G, Chakravarti A, Kubo M, Tedrow UB, Rose LM, Ridker PM, Conen D, Tsunoda T,
2908 Furukawa T, Sotoodehnia N, Xu S, Kamatani N, Levy D, Nakamura Y, Parvez B, Mahida S, Furie KL,
2909 Rosand J, Muhammad R, Psaty BM, Meitinger T, Perz S, Wichmann HE, Witteman JC, Kao WH,
2910 Kathiresan S, Roden DM, Uitterlinden AG, Rivadeneira F, McKnight B, Sjogren M, Newman AB, Liu
2911 Y, Gollob MH, Melander O, Tanaka T, Stricker BH, Felix SB, Alonso A, Darbar D, Barnard J,
2912 Chasman DI, Heckbert SR, Benjamin EJ, Gudnason V, Kaab S. Meta-analysis identifies six new
2913 susceptibility loci for atrial fibrillation. *Nat Genet* 2012;**44**:670-675.
- 2914 61. Olesen MS, Nielsen MW, Haunso S, Svendsen JH. Atrial fibrillation: the role of common and
2915 rare genetic variants. *Eur J Hum Genet* 2014;**22**:297-306.
- 2916 62. Sinner MF, Tucker NR, Lunetta KL, Ozaki K, Smith JG, Trompet S, Bis JC, Lin H, Chung MK,
2917 Nielsen JB, Lubitz SA, Krijthe BP, Magnani JW, Ye J, Gollob MH, Tsunoda T, Muller-Nurasyid M,
2918 Lichtner P, Peters A, Dolmatova E, Kubo M, Smith JD, Psaty BM, Smith NL, Jukema JW, Chasman
2919 DI, Albert CM, Ebana Y, Furukawa T, Macfarlane PW, Harris TB, Darbar D, Dorr M, Holst AG,
2920 Svendsen JH, Hofman A, Uitterlinden AG, Gudnason V, Isobe M, Malik R, Dichgans M, Rosand J,
2921 Van Wagener DR, METASTROKE Consortium, AFGen Consortium, Benjamin EJ, Milan DJ, Melander
2922 O, Heckbert SR, Ford I, Liu Y, Barnard J, Olesen MS, Stricker BH, Tanaka T, Kaab S, Ellinor PT.
2923 Integrating genetic, transcriptional, and functional analyses to identify 5 novel genes for atrial
2924 fibrillation. *Circulation* 2014;**130**:1225-1235.
- 2925 63. Gudbjartsson DF, Arnar DO, Helgadóttir A, Gretarsdóttir S, Holm H, Sigurdsson A,
2926 Jonasdóttir A, Baker A, Thorleifsson G, Kristjansson K, Palsson A, Blondal T, Sulem P, Backman VM,
2927 Hardarson GA, Palsdóttir E, Helgason A, Sigurjonsdóttir R, Sverrisson JT, Kostulas K, Ng MC, Baum
2928 L, So WY, Wong KS, Chan JC, Furie KL, Greenberg SM, Sale M, Kelly P, MacRae CA, Smith EE,
2929 Rosand J, Hillert J, Ma RC, Ellinor PT, Thorgeirsson G, Gulcher JR, Kong A, Thorsteinsdóttir U,
2930 Stefansson K. Variants conferring risk of atrial fibrillation on chromosome 4q25. *Nature* 2007;**448**:353-
2931 357.
- 2932 64. Lubitz SA, Lunetta KL, Lin H, Arking DE, Trompet S, Li G, Krijthe BP, Chasman DI, Barnard J,
2933 Kleber ME, Dorr M, Ozaki K, Smith AV, Muller-Nurasyid M, Walter S, Agarwal SK, Bis JC, Brody JA,
2934 Chen LY, Everett BM, Ford I, Franco OH, Harris TB, Hofman A, Kaab S, Mahida S, Kathiresan S,
2935 Kubo M, Launer LJ, Macfarlane PW, Magnani JW, McKnight B, McManus DD, Peters A, Psaty BM,
2936 Rose LM, Rotter JI, Silbernagel G, Smith JD, Sotoodehnia N, Stott DJ, Taylor KD, Tomaschitz A,
2937 Tsunoda T, Uitterlinden AG, Van Wagener DR, Volker U, Volzke H, Murabito JM, Sinner MF,
2938 Gudnason V, Felix SB, Marz W, Chung M, Albert CM, Stricker BH, Tanaka T, Heckbert SR, Jukema
2939 JW, Alonso A, Benjamin EJ, Ellinor PT. Novel genetic markers associate with atrial fibrillation risk in
2940 Europeans and Japanese. *J Am Coll Cardiol* 2014;**63**:1200-1210.
- 2941 65. Lemmens R, Buysschaert I, Geelen V, Fernandez-Cadenas I, Montaner J, Schmidt H,
2942 Schmidt R, Attia J, Maguire J, Levi C, Jood K, Blomstrand C, Jern C, Wnuk M, Slowik A, Lambrechts
2943 D, Thijs V, International Stroke Genetics Consortium. The association of the 4q25 susceptibility
2944 variant for atrial fibrillation with stroke is limited to stroke of cardioembolic etiology. *Stroke*
2945 2010;**41**:1850-1857.
- 2946 66. Tada H, Shiffman D, Smith JG, Sjogren M, Lubitz SA, Ellinor PT, Louie JZ, Catanese JJ,
2947 Engstrom G, Devlin JJ, Kathiresan S, Melander O. Twelve-single nucleotide polymorphism genetic
2948 risk score identifies individuals at increased risk for future atrial fibrillation and stroke. *Stroke*
2949 2014;**45**:2856-2862.
- 2950 67. Wang J, Klysis E, Sood S, Johnson RL, Wehrens XH, Martin JF. Pitx2 prevents susceptibility
2951 to atrial arrhythmias by inhibiting left-sided pacemaker specification. *Proc Natl Acad Sci U S A*
2952 2010;**107**:9753-9758.
- 2953 68. Franco D, Chinchilla A, Daimi H, Dominguez JN, Aranega A. Modulation of conductive
2954 elements by Pitx2 and their impact on atrial arrhythmogenesis. *Cardiovasc Res* 2011;**91**:223-231.
- 2955 69. Kirchhof P, Kahr PC, Kaese S, Piccini I, Vokshi I, Scheld HH, Rotering H, Fortmueller L,
2956 Laakmann S, Verheule S, Schotten U, Fabritz L, Brown NA. PITX2c is expressed in the adult left

- 2957 atrium, and reducing Pitx2c expression promotes atrial fibrillation inducibility and complex changes in
2958 gene expression. *Circ Cardiovasc Genet* 2011;**4**:123-133.
- 2959 70. Wang J, Bai Y, Li N, Ye W, Zhang M, Greene SB, Tao Y, Chen Y, Wehrens XH, Martin JF.
2960 Pitx2-microRNA pathway that delimits sinoatrial node development and inhibits predisposition to atrial
2961 fibrillation. *Proc Natl Acad Sci U S A* 2014.
- 2962 71. Husser D, Adams V, Piorkowski C, Hindricks G, Bollmann A. Chromosome 4q25 variants and
2963 atrial fibrillation recurrence after catheter ablation. *J Am Coll Cardiol* 2010;**55**:747-753.
- 2964 72. Parvez B, Shoemaker MB, Muhammad R, Richardson R, Jiang L, Blair MA, Roden DM,
2965 Darbar D. Common genetic polymorphism at 4q25 locus predicts atrial fibrillation recurrence after
2966 successful cardioversion. *Heart Rhythm* 2013;**10**:849-855.
- 2967 73. Benjamin Shoemaker M, Muhammad R, Parvez B, White BW, Streur M, Song Y, Stubblefield
2968 T, Kucera G, Blair M, Rytlewski J, Parvathaneni S, Nagarakanti R, Saavedra P, Ellis CR, Patrick
2969 Whalen S, Roden DM, Darbar RD. Common atrial fibrillation risk alleles at 4q25 predict recurrence
2970 after catheter-based atrial fibrillation ablation. *Heart Rhythm* 2013;**10**:394-400.
- 2971 74. Parvez B, Vaglio J, Rowan S, Muhammad R, Kucera G, Stubblefield T, Carter S, Roden D,
2972 Darbar D. Symptomatic response to antiarrhythmic drug therapy is modulated by a common single
2973 nucleotide polymorphism in atrial fibrillation. *J Am Coll Cardiol* 2012;**60**:539-545.
- 2974 75. Kirchhof P, Sipido KR, Cowie MR, Eschenhagen T, Fox KA, Katus H, Schroeder S, Schunkert
2975 H, Priori S, ESC CRT R&D and European Affairs Work Shop on Personalized Medicine. The
2976 continuum of personalized cardiovascular medicine: a position paper of the European Society of
2977 Cardiology. *Eur Heart J* 2014;**35**:3250-3257.
- 2978 76. Kirchhof P, Breithardt G, Aliot E, Al Khatib S, Apostolakis S, Auricchio A, Bailleul C, Bax J,
2979 Benninger G, Blomstrom-Lundqvist C, Boersma L, Boriani G, Brandes A, Brown H, Brueckmann M,
2980 Calkins H, Casadei B, Clemens A, Crijns H, Derwand R, Dobrev D, Ezekowitz M, Fetsch T, Gerth A,
2981 Gillis A, Gulizia M, Hack G, Haegeli L, Hatem S, Georg Hausler K, Heidebuchel H, Hernandez-Brichis
2982 J, Jais P, Kappenberger L, Kautzner J, Kim S, Kuck KH, Lane D, Leute A, Lewalter T, Meyer R, Mont
2983 L, Moses G, Mueller M, Munzel F, Nabauer M, Nielsen JC, Oeff M, Oto A, Pieske B, Pisters R,
2984 Potpara T, Rasmussen L, Ravens U, Reiffel J, Richard-Lordereau I, Schafer H, Schotten U, Stegink
2985 W, Stein K, Steinbeck G, Szumowski L, Tavazzi L, Themistoclakis S, Thomitzek K, Van Gelder IC,
2986 von Stritzky B, Vincent A, Werring D, Willems S, Lip GY, Camm AJ. Personalized management of
2987 atrial fibrillation: Proceedings from the fourth Atrial Fibrillation competence NETwork/European Heart
2988 Rhythm Association consensus conference. *Europace* 2013;**15**:1540-1556.
- 2989 77. Ackerman MJ, Priori SG, Willems S, Berul C, Brugada R, Calkins H, Camm AJ, Ellinor PT,
2990 Gollob M, Hamilton R, Hershberger RE, Judge DP, Le Marec H, McKenna WJ, Schulze-Bahr E,
2991 Semsarian C, Towbin JA, Watkins H, Wilde A, Wolpert C, Zipes DP, Heart Rhythm Society, European
2992 Heart Rhythm Association. HRS/EHRA expert consensus statement on the state of genetic testing for
2993 the channelopathies and cardiomyopathies: this document was developed as a partnership between
2994 the Heart Rhythm Society (HRS) and the European Heart Rhythm Association (EHRA). *Europace*
2995 2011;**13**:1077-1109.
- 2996 78. Anne W, Willems R, Roskams T, Sergeant P, Herijgers P, Holemans P, Ector H, Heidebuchel
2997 H. Matrix metalloproteinases and atrial remodeling in patients with mitral valve disease and atrial
2998 fibrillation. *Cardiovasc Res* 2005;**67**:655-666.
- 2999 79. Chimenti C, Russo MA, Carpi A, Frustaci A. Histological substrate of human atrial fibrillation.
3000 *Biomed Pharmacother* 2010;**64**:177-183.
- 3001 80. Nguyen BL, Fishbein MC, Chen LS, Chen PS, Masroor S. Histopathological substrate for
3002 chronic atrial fibrillation in humans. *Heart Rhythm* 2009;**6**:454-460.
- 3003 81. Frustaci A, Chimenti C, Bellocci F, Morgante E, Russo MA, Maseri A. Histological substrate of
3004 atrial biopsies in patients with lone atrial fibrillation. *Circulation* 1997;**96**:1180-1184.
- 3005 82. Venticlef N, Guglielmi V, Balse E, Gaborit B, Cotillard A, Atassi F, Amour J, Leprince P,
3006 Dutour A, Clement K, Hatem SN. Human epicardial adipose tissue induces fibrosis of the atrial
3007 myocardium through the secretion of adipo-fibrokinases. *Eur Heart J* 2013.
- 3008 83. Rocken C, Peters B, Juenemann G, Saeger W, Klein HU, Huth C, Roessner A, Goette A.
3009 Atrial amyloidosis: an arrhythmogenic substrate for persistent atrial fibrillation. *Circulation*
3010 2002;**106**:2091-2097.
- 3011 84. Schotten U, Ausma J, Stellbrink C, Sabatschus I, Vogel M, Frechen D, Schoendube F,
3012 Hanrath P, Allessie MA. Cellular mechanisms of depressed atrial contractility in patients with chronic
3013 atrial fibrillation. *Circulation* 2001;**103**:691-698.
- 3014 85. Allessie MA, de Groot NM, Houben RP, Schotten U, Boersma E, Smeets JL, Crijns HJ.
3015 Electropathological substrate of long-standing persistent atrial fibrillation in patients with structural
3016 heart disease: longitudinal dissociation. *Circ Arrhythm Electrophysiol* 2010;**3**:606-615.

- 3017 86. Spach MS, Josephson ME. Initiating reentry: the role of nonuniform anisotropy in small
3018 circuits. *J Cardiovasc Electrophysiol* 1994;**5**:182-209.
- 3019 87. Shinagawa K, Shi YF, Tardif JC, Leung TK, Nattel S. Dynamic nature of atrial fibrillation
3020 substrate during development and reversal of heart failure in dogs. *Circulation* 2002;**105**:2672-2678.
- 3021 88. Lim HS, Willoughby SR, Schultz C, Gan C, Alasady M, Lau DH, Leong DP, Brooks AG,
3022 Young GD, Kistler PM, Kalman JM, Worthley MI, Sanders P. Effect of atrial fibrillation on atrial
3023 thrombogenesis in humans: impact of rate and rhythm. *J Am Coll Cardiol* 2013;**61**:852-860.
- 3024 89. Hijazi Z, Oldgren J, Siegbahn A, Granger CB, Wallentin L. Biomarkers in atrial fibrillation: a
3025 clinical review. *Eur Heart J* 2013;**34**:1475-1480.
- 3026 90. Xu J, Cui G, Esmailian F, Plunkett M, Marelli D, Ardehali A, Odim J, Laks H, Sen L. Atrial
3027 extracellular matrix remodeling and the maintenance of atrial fibrillation. *Circulation* 2004;**109**:363-
3028 368.
- 3029 91. Gramley F, Lorenzen J, Plisiene J, Rakauskas M, Benetis R, Schmid M, Autschbach R,
3030 Knackstedt C, Schimpf T, Mischke K, Gressner A, Hanrath P, Kelm M, Schauerte P. Decreased
3031 plasminogen activator inhibitor and tissue metalloproteinase inhibitor expression may promote
3032 increased metalloproteinase activity with increasing duration of human atrial fibrillation. *J Cardiovasc*
3033 *Electrophysiol* 2007;**18**:1076-1082.
- 3034 92. Hatem SN, Sanders P. Epicardial adipose tissue and atrial fibrillation. *Cardiovasc Res*
3035 2014;**102**:205-213.
- 3036 93. Leone O, Boriani G, Chiappini B, Pacini D, Cenacchi G, Martin Suarez S, Rapezzi C, Bacchi
3037 Reggiani ML, Marinelli G. Amyloid deposition as a cause of atrial remodelling in persistent valvular
3038 atrial fibrillation. *Eur Heart J* 2004;**25**:1237-1241.
- 3039 94. Dobrev D, Friedrich A, Voigt N, Jost N, Wettwer E, Christ T, Knaut M, Ravens U. The G
3040 protein-gated potassium current I(K,ACh) is constitutively active in patients with chronic atrial
3041 fibrillation. *Circulation* 2005;**112**:3697-3706.
- 3042 95. Van Wagoner DR, Pond AL, Lamorgese M, Rossie SS, McCarthy PM, Nerbonne JM. Atrial L-
3043 type Ca²⁺ currents and human atrial fibrillation. *Circ Res* 1999;**85**:428-436.
- 3044 96. Schotten U, Verheule S, Kirchhof P, Goette A. Pathophysiological mechanisms of atrial
3045 fibrillation: a translational appraisal. *Physiol Rev* 2011;**91**:265-325.
- 3046 97. Voigt N, Heijman J, Wang Q, Chiang DY, Li N, Karck M, Wehrens XH, Nattel S, Dobrev D.
3047 Cellular and molecular mechanisms of atrial arrhythmogenesis in patients with paroxysmal atrial
3048 fibrillation. *Circulation* 2014;**129**:145-156.
- 3049 98. Voigt N, Li N, Wang Q, Wang W, Trafford AW, Abu-Taha I, Sun Q, Wieland T, Ravens U,
3050 Nattel S, Wehrens XH, Dobrev D. Enhanced sarcoplasmic reticulum Ca²⁺ leak and increased Na⁺-
3051 Ca²⁺ exchanger function underlie delayed afterdepolarizations in patients with chronic atrial
3052 fibrillation. *Circulation* 2012;**125**:2059-2070.
- 3053 99. Polontchouk L, Haefliger JA, Ebelt B, Schaefer T, Stuhlmann D, Mehlhorn U, Kuhn-Regnier F,
3054 De Vivie ER, Dhein S. Effects of chronic atrial fibrillation on gap junction distribution in human and rat
3055 atria. *J Am Coll Cardiol* 2001;**38**:883-891.
- 3056 100. Aime-Sempe C, Folliguet T, Rucker-Martin C, Krajewska M, Krajewska S, Heimburger M,
3057 Aubier M, Mercadier JJ, Reed JC, Hatem SN. Myocardial cell death in fibrillating and dilated human
3058 right atria. *J Am Coll Cardiol* 1999;**34**:1577-1586.
- 3059 101. Spach MS, Heidlage JF, Barr RC, Dolber PC. Cell size and communication: role in structural
3060 and electrical development and remodeling of the heart. *Heart Rhythm* 2004;**1**:500-515.
- 3061 102. Skolidis EI, Hamilos MI, Karalis IK, Chlouverakis G, Kochiadakis GE, Vardas PE. Isolated
3062 atrial microvascular dysfunction in patients with lone recurrent atrial fibrillation. *J Am Coll Cardiol*
3063 2008;**51**:2053-2057.
- 3064 103. Barretto AC, Mady C, Nussbacher A, Ianni BM, Oliveira SA, Jatene A, Ramires JA. Atrial
3065 fibrillation in endomyocardial fibrosis is a marker of worse prognosis. *Int J Cardiol* 1998;**67**:19-25.
- 3066 104. Levy S. Factors predisposing to the development of atrial fibrillation. *Pacing Clin*
3067 *Electrophysiol* 1997;**20**:2670-2674.
- 3068 105. Chen PS, Chen LS, Fishbein MC, Lin SF, Nattel S. Role of the autonomic nervous system in
3069 atrial fibrillation: pathophysiology and therapy. *Circ Res* 2014;**114**:1500-1515.
- 3070 106. Christ T, Rozmaritsa N, Engel A, Berk E, Knaut M, Metzner K, Canteras M, Ravens U,
3071 Kaumann A. Arrhythmias, elicited by catecholamines and serotonin, vanish in human chronic atrial
3072 fibrillation. *Proc Natl Acad Sci U S A* 2014;**111**:11193-11198.
- 3073 107. Greiser M, Kerfant BG, Williams GS, Voigt N, Harks E, Dibb KM, Giese A, Meszaros J,
3074 Verheule S, Ravens U, Allessie MA, Gammie JS, van der Velden J, Lederer WJ, Dobrev D, Schotten
3075 U. Tachycardia-induced silencing of subcellular Ca²⁺ signaling in atrial myocytes. *J Clin Invest*
3076 2014;**124**:4759-4772.

- 3077 108. Haissaguerre M, Jais P, Shah DC, Takahashi A, Hocini M, Quiniou G, Garrigue S, Le
3078 Mouroux A, Le Metayer P, Clementy J. Spontaneous initiation of atrial fibrillation by ectopic beats
3079 originating in the pulmonary veins. *N Engl J Med* 1998;**339**:659-666.
- 3080 109. Patterson E, Jackman WM, Beckman KJ, Lazzara R, Lockwood D, Scherlag BJ, Wu R, Po S.
3081 Spontaneous pulmonary vein firing in man: relationship to tachycardia-pause early
3082 afterdepolarizations and triggered arrhythmia in canine pulmonary veins in vitro. *J Cardiovasc*
3083 *Electrophysiol* 2007;**18**:1067-1075.
- 3084 110. Ateniya F, Almendral J, Moreno J, Vaidyanathan R, Talkachou A, Kalifa J, Arenal A,
3085 Villacastin JP, Torrecilla EG, Sanchez A, Ploutz-Snyder R, Jalife J, Berenfeld O. Activation of inward
3086 rectifier potassium channels accelerates atrial fibrillation in humans: evidence for a reentrant
3087 mechanism. *Circulation* 2006;**114**:2434-2442.
- 3088 111. Mandapati R, Skanes A, Chen J, Berenfeld O, Jalife J. Stable microreentrant sources as a
3089 mechanism of atrial fibrillation in the isolated sheep heart. *Circulation* 2000;**101**:194-199.
- 3090 112. Sahadevan J, Ryu K, Peltz L, Khrestian CM, Stewart RW, Markowitz AH, Waldo AL.
3091 Epicardial mapping of chronic atrial fibrillation in patients: preliminary observations. *Circulation*
3092 2004;**110**:3293-3299.
- 3093 113. Sanders P, Nalliah CJ, Dubois R, Takahashi Y, Hocini M, Rotter M, Rostock T, Sacher F, Hsu
3094 LF, Jonsson A, O'Neill MD, Jais P, Haissaguerre M. Frequency mapping of the pulmonary veins in
3095 paroxysmal versus permanent atrial fibrillation. *J Cardiovasc Electrophysiol* 2006;**17**:965-972.
- 3096 114. Moe GK, Abildskov JA. Atrial fibrillation as a self-sustaining arrhythmia independent of focal
3097 discharge. *Am Heart J* 1959;**58**:59-70.
- 3098 115. Cox JL, Canavan TE, Schuessler RB, Cain ME, Lindsay BD, Stone C, Smith PK, Corr PB,
3099 Boineau JP. The surgical treatment of atrial fibrillation. II. Intraoperative electrophysiologic mapping
3100 and description of the electrophysiologic basis of atrial flutter and atrial fibrillation. *J Thorac*
3101 *Cardiovasc Surg* 1991;**101**:406-426.
- 3102 116. Narayan SM, Krummen DE, Shivkumar K, Clopton P, Rappel WJ, Miller JM. Treatment of
3103 atrial fibrillation by the ablation of localized sources: CONFIRM (Conventional Ablation for Atrial
3104 Fibrillation With or Without Focal Impulse and Rotor Modulation) trial. *J Am Coll Cardiol* 2012;**60**:628-
3105 636.
- 3106 117. Haissaguerre M, Hocini M, Denis A, Shah AJ, Komatsu Y, Yamashita S, Daly M, Amraoui S,
3107 Zellerhoff S, Picat MQ, Quotb A, Jesel L, Lim H, Ploux S, Bordachar P, Attuel G, Meillet V, Ritter P,
3108 Derval N, Sacher F, Bernus O, Cochet H, Jais P, Dubois R. Driver domains in persistent atrial
3109 fibrillation. *Circulation* 2014;**130**:530-538.
- 3110 118. Fetsch T, Bauer P, Engberding R, Koch HP, Luki J, Meinertz T, Oeff M, Seipel L, Trappe HJ,
3111 Treese N, Breithardt G. Prevention of atrial fibrillation after cardioversion: results of the PAFAC trial.
3112 *Eur Heart J* 2004;**25**:1385-1394.
- 3113 119. Hindricks G, Piorkowski C, Tanner H, Kobza R, Gerds-Li JH, Carbucicchio C, Kottkamp H.
3114 Perception of atrial fibrillation before and after radiofrequency catheter ablation: relevance of
3115 asymptomatic arrhythmia recurrence. *Circulation* 2005;**112**:307-313.
- 3116 120. Kirchhof P, Bax J, Blomstrom-Lundquist C, Calkins H, Camm AJ, Cappato R, Cosio F, Crijns
3117 H, Diener HC, Goette A, Israel CW, Kuck KH, Lip GY, Nattel S, Page RL, Ravens U, Schotten U,
3118 Steinbeck G, Vardas P, Waldo A, Wegscheider K, Willems S, Breithardt G. Early and comprehensive
3119 management of atrial fibrillation: executive summary of the proceedings from the 2nd AFNET-EHRA
3120 consensus conference 'research perspectives in AF'. *Eur Heart J* 2009;**30**:2969-2977c.
- 3121 121. Xiong Q, Proietti M, Senoo K, Lip GY. Asymptomatic versus symptomatic atrial fibrillation: A
3122 systematic review of age/gender differences and cardiovascular outcomes. *Int J Cardiol*
3123 2015;**191**:172-177.
- 3124 122. Savelieva I, Camm AJ. Clinical relevance of silent atrial fibrillation: prevalence, prognosis,
3125 quality of life, and management. *J Interv Card Electrophysiol* 2000;**4**:369-382.
- 3126 123. Friberg L, Hammar N, Rosenqvist M. Stroke in paroxysmal atrial fibrillation: report from the
3127 Stockholm Cohort of Atrial Fibrillation. *Eur Heart J* 2010;**31**:967-975.
- 3128 124. Vanassche T, Lauw MN, Eikelboom JW, Healey JS, Hart RG, Alings M, Avezum A, Diaz R,
3129 Hohnloser SH, Lewis BS, Shestakovska O, Wang J, Connolly SJ. Risk of ischaemic stroke according
3130 to pattern of atrial fibrillation: analysis of 6563 aspirin-treated patients in ACTIVE-A and AVERROES.
3131 *Eur Heart J* 2015;**36**:281-287a.
- 3132 125. Steinberg BA, Hellkamp AS, Lokhnygina Y, Patel MR, Breithardt G, Hankey GJ, Becker RC,
3133 Singer DE, Halperin JL, Hacke W, Nessel CC, Berkowitz SD, Mahaffey KW, Fox KA, Califf RM,
3134 Piccini JP. Higher risk of death and stroke in patients with persistent vs. paroxysmal atrial fibrillation:
3135 results from the ROCKET-AF Trial. *Eur Heart J* 2015;**36**:288-296.

- 3136 126. Fitzmaurice DA, Hobbs FD, Jowett S, Mant J, Murray ET, Holder R, Raftery JP, Bryan S,
3137 Davies M, Lip GY, Allan TF. Screening versus routine practice in detection of atrial fibrillation in
3138 patients aged 65 or over: cluster randomised controlled trial. *BMJ* 2007;**335**:383.
- 3139 127. Rizos T, Guntner J, Jenetzky E, Marquardt L, Reichardt C, Becker R, Reinhardt R, Hepp T,
3140 Kirchhof P, Aleychnichenko E, Ringleb P, Hacke W, Veltkamp R. Continuous stroke unit
3141 electrocardiographic monitoring versus 24-hour Holter electrocardiography for detection of
3142 paroxysmal atrial fibrillation after stroke. *Stroke* 2012;**43**:2689-2694.
- 3143 128. Gladstone DJ, Spring M, Dorian P, Panzov V, Thorpe KE, Hall J, Vaid H, O'Donnell M,
3144 Laupacis A, Cote R, Sharma M, Blakely JA, Shuaib A, Hachinski V, Coutts SB, Sahlas DJ, Teal P, Yip
3145 S, Spence JD, Buck B, Verreault S, Casaubon LK, Penn A, Selchen D, Jin A, Howse D, Mehdiratna M,
3146 Boyle K, Aviv R, Kapral MK, Mamdani M, EMBRACE Investigators and Coordinators. Atrial fibrillation
3147 in patients with cryptogenic stroke. *N Engl J Med* 2014;**370**:2467-2477.
- 3148 129. Friberg L, Engdahl J, Frykman V, Svennberg E, Levin LA, Rosenqvist M. Population
3149 screening of 75- and 76-year-old men and women for silent atrial fibrillation (STROKESTOP).
3150 *Europace* 2013;**15**:135-140.
- 3151 130. Davis RC, Hobbs FD, Kenkre JE, Roalfe AK, Iles R, Lip GY, Davies MK. Prevalence of atrial
3152 fibrillation in the general population and in high-risk groups: the ECHOES study. *Europace*
3153 2012;**14**:1553-1559.
- 3154 131. Hobbs FD, Fitzmaurice DA, Mant J, Murray E, Jowett S, Bryan S, Raftery J, Davies M, Lip G.
3155 A randomised controlled trial and cost-effectiveness study of systematic screening (targeted and total
3156 population screening) versus routine practice for the detection of atrial fibrillation in people aged 65
3157 and over. The SAFE study. *Health Technol Assess* 2005;**9**:iii-iv, ix-x, 1-74.
- 3158 132. Aronsson M, Svennberg E, Rosenqvist M, Engdahl J, Al-Khalili F, Friberg L, Frykman-Kull V,
3159 Levin LA. Cost-effectiveness of mass screening for untreated atrial fibrillation using intermittent ECG
3160 recording. *Europace* 2015;**17**:1023-1029.
- 3161 133. Levin LA, Husberg M, Sobocinski PD, Kull VF, Friberg L, Rosenqvist M, Davidson T. A cost-
3162 effectiveness analysis of screening for silent atrial fibrillation after ischaemic stroke. *Europace*
3163 2015;**17**:207-214.
- 3164 134. Lowres N, Neubeck L, Redfern J, Freedman SB. Screening to identify unknown atrial
3165 fibrillation. A systematic review. *Thromb Haemost* 2013;**110**:213-222.
- 3166 135. Engdahl J, Andersson L, Mirskaya M, Rosenqvist M. Stepwise screening of atrial fibrillation in
3167 a 75-year-old population: implications for stroke prevention. *Circulation* 2013;**127**:930-937.
- 3168 136. Kaleschke G, Hoffmann B, Drewitz I, Steinbeck G, Naebauer M, Goette A, Breithardt G,
3169 Kirchhof P. Prospective, multicentre validation of a simple, patient-operated electrocardiographic
3170 system for the detection of arrhythmias and electrocardiographic changes. *Europace* 2009;**11**:1362-
3171 1368.
- 3172 137. Tieleman RG, Plantinga Y, Rinkes D, Bartels GL, Pasma JL, Cator R, Hofman C, Houben RP.
3173 Validation and clinical use of a novel diagnostic device for screening of atrial fibrillation. *Europace*
3174 2014;**16**:1291-1295.
- 3175 138. Barrett PM, Komatireddy R, Haaser S, Topol S, Sheard J, Encinas J, Fought AJ, Topol EJ.
3176 Comparison of 24-hour Holter monitoring with 14-day novel adhesive patch electrocardiographic
3177 monitoring. *Am J Med* 2014;**127**:95 e11-97.
- 3178 139. Lowres N, Neubeck L, Salkeld G, Krass I, McLachlan AJ, Redfern J, Bennett AA, Briffa T,
3179 Bauman A, Martinez C, Wallenhorst C, Lau JK, Brieger DB, Sy RW, Freedman SB. Feasibility and
3180 cost-effectiveness of stroke prevention through community screening for atrial fibrillation using iPhone
3181 ECG in pharmacies. The SEARCH-AF study. *Thromb Haemost* 2014;**111**:1167-1176.
- 3182 140. Quinn FR, Gladstone D. Screening for undiagnosed atrial fibrillation in the community. *Curr*
3183 *Opin Cardiol* 2014;**29**:28-35.
- 3184 141. Healey JS, Connolly SJ, Gold MR, Israel CW, Van Gelder IC, Capucci A, Lau CP, Fain E,
3185 Yang S, Bailleul C, Morillo CA, Carlson M, Themeles E, Kaufman ES, Hohnloser SH, ASSERT
3186 Investigators. Subclinical atrial fibrillation and the risk of stroke. *N Engl J Med* 2012;**366**:120-129.
- 3187 142. Hindricks G, Pokushalov E, Urban L, Taborisky M, Kuck KH, Lebedev D, Rieger G,
3188 Purerfellner H. Performance of a new leadless implantable cardiac monitor in detecting and
3189 quantifying atrial fibrillation - results of the XPECT trial. *Circ Arrhythm Electrophysiol* 2010;**3**:141-147.
- 3190 143. Brambatti M, Connolly SJ, Gold MR, Morillo CA, Capucci A, Muto C, Lau CP, Van Gelder IC,
3191 Hohnloser SH, Carlson M, Fain E, Nakamya J, Mairesse GH, Halytska M, Deng WQ, Israel CW,
3192 Healey JS, ASSERT Investigators. Temporal relationship between subclinical atrial fibrillation and
3193 embolic events. *Circulation* 2014;**129**:2094-2099.
- 3194 144. Boriani G, Glotzer TV, Santini M, West TM, De Melis M, Sepsi M, Gasparini M, Lewalter T,
3195 Camm JA, Singer DE. Device-detected atrial fibrillation and risk for stroke: an analysis of >10,000

- 3196 patients from the SOS AF project (Stroke preventiOn Strategies based on Atrial Fibrillation
3197 information from implanted devices). *Eur Heart J* 2014;**35**:508-516.
- 3198 145. Santini M, Gasparini M, Landolina M, Lunati M, Proclemer A, Padeletti L, Catanzariti D, Molon
3199 G, Botto GL, La Rocca L, Grammatico A, Boriani G. Device-detected atrial tachyarrhythmias predict
3200 adverse outcome in real-world patients with implantable biventricular defibrillators. *J Am Coll Cardiol*
3201 2011;**57**:167-172.
- 3202 146. Daoud EG, Glotzer TV, Wyse DG, Ezekowitz MD, Hilker C, Koehler J, Ziegler PD. Temporal
3203 relationship of atrial tachyarrhythmias, cerebrovascular events, and systemic emboli based on stored
3204 device data: a subgroup analysis of TRENDS. *Heart Rhythm* 2011;**8**:1416-1423.
- 3205 147. Glotzer TV, Daoud EG, Wyse DG, Singer DE, Ezekowitz MD, Hilker C, Miller C, Qi D, Ziegler
3206 PD. The relationship between daily atrial tachyarrhythmia burden from implantable device diagnostics
3207 and stroke risk: the TRENDS study. *Circ Arrhythm Electrophysiol* 2009;**2**:474-480.
- 3208 148. Lamas G. How much atrial fibrillation is too much atrial fibrillation? *N Engl J Med*
3209 2012;**366**:178-180.
- 3210 149. Kirchhof P, Lip GY, Van Gelder IC, Bax J, Hylek E, Kaab S, Schotten U, Wegscheider K,
3211 Boriani G, Brandes A, Ezekowitz M, Diener H, Haegeli L, Heidbuchel H, Lane D, Mont L, Willems S,
3212 Dorian P, Aunes-Jansson M, Blomstrom-Lundqvist C, Borentain M, Breitenstein S, Brueckmann M,
3213 Cater N, Clemens A, Dobrev D, Dubner S, Edvardsson NG, Friberg L, Goette A, Gulizia M, Hatala R,
3214 Horwood J, Szumowski L, Kappenberger L, Kautzner J, Leute A, Lobban T, Meyer R, Millerhagen J,
3215 Morgan J, Muenzel F, Nabauer M, Baertels C, Oeff M, Paar D, Polifka J, Ravens U, Rosin L, Stegink
3216 W, Steinbeck G, Vardas P, Vincent A, Walter M, Breithardt G, Camm AJ. Comprehensive risk
3217 reduction in patients with atrial fibrillation: emerging diagnostic and therapeutic options--a report from
3218 the 3rd Atrial Fibrillation Competence NETwork/European Heart Rhythm Association consensus
3219 conference. *Europace* 2012;**14**:8-27.
- 3220 150. Kirchhof P, Lip GY, Van Gelder IC, Bax J, Hylek E, Kaab S, Schotten U, Wegscheider K,
3221 Boriani G, Ezekowitz M, Diener H, Heidbuchel H, Lane D, Mont L, Willems S, Dorian P, Vardas P,
3222 Breithardt G, Camm AJ. Comprehensive risk reduction in patients with atrial fibrillation: Emerging
3223 diagnostic and therapeutic options. Executive summary of the report from the 3rd AFNET/EHRA
3224 consensus conference. *Thromb Haemost* 2011;**106**:1012-1019.
- 3225 151. Sposato LA, Cipriano LE, Saposnik G, Ruiz Vargas E, Riccio PM, Hachinski V. Diagnosis of
3226 atrial fibrillation after stroke and transient ischaemic attack: a systematic review and meta-analysis.
3227 *Lancet Neurol* 2015;**14**:377-387.
- 3228 152. Thijs VN, Brachmann J, Morillo CA, Passman RS, Sanna T, Bernstein RA, Diener HC, Di
3229 Lazzaro V, Rymer MM, Hogge L, Rogers TB, Ziegler PD, Assar MD. Predictors for atrial fibrillation
3230 detection after cryptogenic stroke: Results from CRYSTAL AF. *Neurology* 2016;**86**:261-269.
- 3231 153. Adams HP, Jr., Bendixen BH, Kappelle LJ, Biller J, Love BB, Gordon DL, Marsh EE, 3rd.
3232 Classification of subtype of acute ischemic stroke. Definitions for use in a multicenter clinical trial.
3233 TOAST. Trial of Org 10172 in Acute Stroke Treatment. *Stroke* 1993;**24**:35-41.
- 3234 154. Hart RG, Diener HC, Coutts SB, Easton JD, Granger CB, O'Donnell MJ, Sacco RL, Connolly
3235 SJ, Cryptogenic Stroke/ESUS International Working Group. Embolic strokes of undetermined source:
3236 the case for a new clinical construct. *Lancet Neurol* 2014;**13**:429-438.
- 3237 155. Mant J, Fitzmaurice DA, Hobbs FD, Jowett S, Murray ET, Holder R, Davies M, Lip GY.
3238 Accuracy of diagnosing atrial fibrillation on electrocardiogram by primary care practitioners and
3239 interpretative diagnostic software: analysis of data from screening for atrial fibrillation in the elderly
3240 (SAFE) trial. *BMJ* 2007;**335**:380.
- 3241 156. Israel CW, Gronefeld G, Ehrlich JR, Li YG, Hohnloser SH. Long-term risk of recurrent atrial
3242 fibrillation as documented by an implantable monitoring device: implications for optimal patient care. *J*
3243 *Am Coll Cardiol* 2004;**43**:47-52.
- 3244 157. Svennberg E, Engdahl J, Al-Khalili F, Friberg L, Frykman V, Rosenqvist M. Mass Screening
3245 for Untreated Atrial Fibrillation: The STROKESTOP Study. *Circulation* 2015;**131**:2176-2184.
- 3246 158. Bun SS, Latcu DG, Marchlinski F, Saudi N. Atrial flutter: more than just one of a kind. *Eur*
3247 *Heart J* 2015;**36**:2356-2363.
- 3248 159. Granada J, Uribe W, Chyou PH, Maassen K, Vierkant R, Smith PN, Hayes J, Eaker E,
3249 Vidaillet H. Incidence and predictors of atrial flutter in the general population. *J Am Coll Cardiol*
3250 2000;**36**:2242-2246.
- 3251 160. Halligan SC, Gersh BJ, Brown RD, Jr., Rosales AG, Munger TM, Shen WK, Hammill SC,
3252 Friedman PA. The natural history of lone atrial flutter. *Ann Intern Med* 2004;**140**:265-268.
- 3253 161. Jahangir A, Lee V, Friedman PA, Trusty JM, Hodge DO, Kopecky SL, Packer DL, Hammill
3254 SC, Shen WK, Gersh BJ. Long-term progression and outcomes with aging in patients with lone atrial
3255 fibrillation: a 30-year follow-up study. *Circulation* 2007;**115**:3050-3056.

- 3256 162. Gillis AM, Rose MS. Temporal patterns of paroxysmal atrial fibrillation following DDDR
3257 pacemaker implantation. *Am J Cardiol* 2000;**85**:1445-1450.
- 3258 163. Charitos EI, Purefellner H, Glotzer TV, Ziegler PD. Clinical classifications of atrial fibrillation
3259 poorly reflect its temporal persistence: insights from 1,195 patients continuously monitored with
3260 implantable devices. *J Am Coll Cardiol* 2014;**63**:2840-2848.
- 3261 164. Banerjee A, Taillandier S, Olesen JB, Lane DA, Lallemand B, Lip GY, Fauchier L. Pattern of
3262 atrial fibrillation and risk of outcomes: the Loire Valley Atrial Fibrillation Project. *Int J Cardiol*
3263 2013;**167**:2682-2687.
- 3264 165. Lee G, Sanders P, Kalman JM. Catheter ablation of atrial arrhythmias: state of the art. *Lancet*
3265 2012;**380**:1509-1519.
- 3266 166. Wyse DG, Van Gelder IC, Ellinor PT, Go AS, Kalman JM, Narayan SM, Nattel S, Schotten U,
3267 Rienstra M. Lone atrial fibrillation: does it exist? *J Am Coll Cardiol* 2014;**63**:1715-1723.
- 3268 167. Andrade J, Khairy P, Dobrev D, Nattel S. The clinical profile and pathophysiology of atrial
3269 fibrillation: relationships among clinical features, epidemiology, and mechanisms. *Circ Res*
3270 2014;**114**:1453-1468.
- 3271 168. Chao TF, Suenari K, Chang SL, Lin YJ, Lo LW, Hu YF, Tuan TC, Tai CT, Tsao HM, Li CH,
3272 Ueng KC, Wu TJ, Chen SA. Atrial substrate properties and outcome of catheter ablation in patients
3273 with paroxysmal atrial fibrillation associated with diabetes mellitus or impaired fasting glucose. *Am J*
3274 *Cardiol* 2010;**106**:1615-1620.
- 3275 169. Albertsen IE, Rasmussen LH, Lane DA, Overvad TF, Skjoth F, Overvad K, Lip GY, Larsen
3276 TB. The impact of smoking on thromboembolism and mortality in patients with incident atrial
3277 fibrillation: insights from the Danish Diet, Cancer, and Health study. *Chest* 2014;**145**:559-566.
- 3278 170. Overvad TF, Rasmussen LH, Skjoth F, Overvad K, Albertsen IE, Lane DA, Lip GY, Larsen
3279 TB. Alcohol intake and prognosis of atrial fibrillation. *Heart* 2013;**99**:1093-1099.
- 3280 171. Daccarett M, Badger TJ, Akoum N, Burgon NS, Mahnkopf C, Vergara G, Kholmovski E,
3281 McGann CJ, Parker D, Brachmann J, Macleod RS, Marrouche NF. Association of left atrial fibrosis
3282 detected by delayed-enhancement magnetic resonance imaging and the risk of stroke in patients with
3283 atrial fibrillation. *J Am Coll Cardiol* 2011;**57**:831-838.
- 3284 172. Neilan TG, Shah RV, Abbasi SA, Farhad H, Groarke JD, Dodson JA, Coelho-Filho O,
3285 McMullan CJ, Heydari B, Michaud GF, John RM, van der Geest R, Steigner ML, Blankstein R,
3286 Jerosch-Herold M, Kwong RY. The incidence, pattern, and prognostic value of left ventricular
3287 myocardial scar by late gadolinium enhancement in patients with atrial fibrillation. *J Am Coll Cardiol*
3288 2013;**62**:2205-2214.
- 3289 173. Marrouche NF, Wilber D, Hindricks G, Jais P, Akoum N, Marchlinski F, Kholmovski E, Burgon
3290 N, Hu N, Mont L, Deneke T, Duytschaever M, Neumann T, Mansour M, Mahnkopf C, Herweg B,
3291 Daoud E, Wissner E, Bansmann P, Brachmann J. Association of atrial tissue fibrosis identified by
3292 delayed enhancement MRI and atrial fibrillation catheter ablation: the DECAAF study. *JAMA*
3293 2014;**311**:498-506.
- 3294 174. Bonizzi P, Zeemering S, Karel JM, Di Marco LY, Uldry L, Van Zaen J, Vesin JM, Schotten U.
3295 Systematic comparison of non-invasive measures for the assessment of atrial fibrillation complexity: a
3296 step forward towards standardization of atrial fibrillation electrogram analysis. *Europace* 2014.
- 3297 175. Kirchhof P, Breithardt G, Bax J, Benninger G, Blomstrom-Lundqvist C, Boriani G, Brandes A,
3298 Brown H, Brueckmann M, Calkins H, Calvert M, Christoffels V, Crijns H, Dobrev D, Ellinor P, Fabritz
3299 L, Fetsch T, Freedman SB, Gerth A, Goette A, Guasch E, Hack G, Haegeli L, Hatem S, Haeusler KG,
3300 Heidebuchel H, Heinrich-Nols J, Hidden-Lucet F, Hindricks G, Juul-Moller S, Kaab S, Kappenberger L,
3301 Kespohl S, Kotecha D, Lane DA, Leute A, Lewalter T, Meyer R, Mont L, Munzel F, Nabauer M,
3302 Nielsen JC, Oeff M, Oldgren J, Oto A, Piccini JP, Pilmeyer A, Potpara T, Ravens U, Reinecke H,
3303 Rostock T, Rustige J, Savelieva I, Schnabel R, Schotten U, Schwichtenberg L, Sinner MF, Steinbeck
3304 G, Stoll M, Tavazzi L, Themistoclakis S, Tse HF, Van Gelder IC, Vardas PE, Varpula T, Vincent A,
3305 Werring D, Willems S, Ziegler A, Lip GY, Camm AJ. A roadmap to improve the quality of atrial
3306 fibrillation management: proceedings from the fifth Atrial Fibrillation Network/European Heart Rhythm
3307 Association consensus conference. *Europace* 2016;**18**:37-50.
- 3308 176. Fabritz L, Guasch E, Antoniadou C, Bardinet I, Benninger G, Betts TR, Brand E, Breithardt G,
3309 Bucklar-Suchankova G, Camm AJ, Cartlidge D, Casadei B, Chua WW, Crijns HJ, Deeks J, Hatem S,
3310 Hidden-Lucet F, Kaab S, Maniadakis N, Martin S, Mont L, Reinecke H, Sinner MF, Schotten U,
3311 Southwood T, Stoll M, Vardas P, Wakili R, West A, Ziegler A, Kirchhof P. Expert consensus
3312 document: Defining the major health modifiers causing atrial fibrillation: a roadmap to underpin
3313 personalized prevention and treatment. *Nat Rev Cardiol* 2016;**13**:230-237.

- 3314 177. Dorian P, Jung W, Newman D, Paquette M, Wood K, Ayers GM, Camm J, Akhtar M, Luderitz
3315 B. The impairment of health-related quality of life in patients with intermittent atrial fibrillation:
3316 implications for the assessment of investigational therapy. *J Am Coll Cardiol* 2000;**36**:1303-1309.
- 3317 178. Sears SF, Serber ER, Alvarez LG, Schwartzman DS, Hoyt RH, Ujhelyi MR. Understanding
3318 atrial symptom reports: objective versus subjective predictors. *Pacing Clin Electrophysiol*
3319 2005;**28**:801-807.
- 3320 179. Peinado R, Arribas F, Ormaetxe JM, Badia X. Variation in quality of life with type of atrial
3321 fibrillation. *Rev Esp Cardiol* 2010;**63**:1402-1409.
- 3322 180. Steg PG, Alam S, Chiang CE, Gamra H, Goethals M, Inoue H, Krapf L, Lewalter T, Merioua I,
3323 Murin J, Naditch-Brule L, Ponikowski P, Rosenqvist M, Silva-Cardoso J, Zharinov O, Brette S, Neill
3324 JO, RealiseAF investigators. Symptoms, functional status and quality of life in patients with controlled
3325 and uncontrolled atrial fibrillation: data from the RealiseAF cross-sectional international registry. *Heart*
3326 2012;**98**:195-201.
- 3327 181. Gronefeld GC, Lilienthal J, Kuck KH, Hohnloser SH, Pharmacological Intervention in Atrial
3328 Fibrillation (PIAF) Study investigators. Impact of rate versus rhythm control on quality of life in patients
3329 with persistent atrial fibrillation. Results from a prospective randomized study. *Eur Heart J*
3330 2003;**24**:1430-1436.
- 3331 182. Pepine CJ. Effects of pharmacologic therapy on health-related quality of life in elderly patients
3332 with atrial fibrillation: a systematic review of randomized and nonrandomized trials. *Clin Med Insights*
3333 *Cardiol* 2013;**7**:1-20.
- 3334 183. Hagens VE, Ranchor AV, Van Sonderen E, Bosker HA, Kamp O, Tijssen JG, Kingma JH,
3335 Crijns HJ, Van Gelder IC, RACE Study Group. Effect of rate or rhythm control on quality of life in
3336 persistent atrial fibrillation. Results from the Rate Control Versus Electrical Cardioversion (RACE)
3337 Study. *J Am Coll Cardiol* 2004;**43**:241-247.
- 3338 184. Weerasooriya R, Davis M, Powell A, Szili-Torok T, Shah C, Whalley D, Kanagaratnam L,
3339 Heddle W, Leitch J, Perks A, Ferguson L, Bulsara M. The Australian intervention randomized control
3340 of rate in atrial fibrillation trial (AIRCRAFT). *J Am Coll Cardiol* 2003;**41**:1697-1702.
- 3341 185. Jones DG, Haldar SK, Hussain W, Sharma R, Francis DP, Rahman-Haley SL, McDonagh TA,
3342 Underwood SR, Markides V, Wong T. A randomized trial to assess catheter ablation versus rate
3343 control in the management of persistent atrial fibrillation in heart failure. *J Am Coll Cardiol*
3344 2013;**61**:1894-1903.
- 3345 186. Rienstra M, Lubitz SA, Mahida S, Magnani JW, Fontes JD, Sinner MF, Van Gelder IC, Ellinor
3346 PT, Benjamin EJ. Symptoms and functional status of patients with atrial fibrillation: state of the art and
3347 future research opportunities. *Circulation* 2012;**125**:2933-2943.
- 3348 187. Arribas F, Ormaetxe JM, Peinado R, Perulero N, Ramirez P, Badia X. Validation of the AF-
3349 QoL, a disease-specific quality of life questionnaire for patients with atrial fibrillation. *Europace*
3350 2010;**12**:364-370.
- 3351 188. Spertus J, Dorian P, Bubien R, Lewis S, Godejohn D, Reynolds MR, Lakkireddy DR, Wimmer
3352 AP, Bhandari A, Burk C. Development and validation of the Atrial Fibrillation Effect on QualiTY-of-Life
3353 (AFEQT) Questionnaire in patients with atrial fibrillation. *Circ Arrhythm Electrophysiol* 2011;**4**:15-25.
- 3354 189. Dorian P, Burk C, Mullin CM, Bubien R, Godejohn D, Reynolds MR, Lakkireddy DR, Wimmer
3355 AP, Bhandari A, Spertus J. Interpreting changes in quality of life in atrial fibrillation: How much change
3356 is meaningful? *Am Heart J* 2013;**166**:381-387.e388.
- 3357 190. Ware JE, Jr., Gandek B. Overview of the SF-36 Health Survey and the International Quality of
3358 Life Assessment (IQOLA) Project. *J Clin Epidemiol* 1998;**51**:903-912.
- 3359 191. Herdman M, Gudex C, Lloyd A, Janssen M, Kind P, Parkin D, Bonnel G, Badia X.
3360 Development and preliminary testing of the new five-level version of EQ-5D (EQ-5D-5L). *Qual Life*
3361 *Res* 2011;**20**:1727-1736.
- 3362 192. Kirchhof P, Auricchio A, Bax J, Crijns H, Camm J, Diener HC, Goette A, Hindricks G,
3363 Hohnloser S, Kappenberger L, Kuck KH, Lip GY, Olsson B, Meinertz T, Priori S, Ravens U, Steinbeck
3364 G, Svernhage E, Tijssen J, Vincent A, Breithardt G. Outcome parameters for trials in atrial fibrillation:
3365 executive summary. *Eur Heart J* 2007;**28**:2803-2817.
- 3366 193. Dorian P, Cvitkovic SS, Kerr CR, Crystal E, Gillis AM, Guerra PG, Mitchell LB, Roy D, Skanes
3367 AC, Wyse DG. A novel, simple scale for assessing the symptom severity of atrial fibrillation at the
3368 bedside: the CCS-SAF scale. *Can J Cardiol* 2006;**22**:383-386.
- 3369 194. Kirchhof P, Ammentorp B, Darius H, De Caterina R, Le Heuzey JY, Schilling RJ, Schmitt J,
3370 Zamorano JL. Management of atrial fibrillation in seven European countries after the publication of the
3371 2010 ESC Guidelines on atrial fibrillation: primary results of the PREvention of thromboemolic
3372 events--European Registry in Atrial Fibrillation (PREFER in AF). *Europace* 2014;**16**:6-14.

- 3373 195. Lip GY, Laroche C, Popescu MI, Rasmussen LH, Vitali-Serdoz L, Dan GA, Kalarus Z, Crijns
3374 HJ, Oliveira MM, Tavazzi L, Maggioni AP, Boriani G. Improved outcomes with European Society of
3375 Cardiology guideline-adherent antithrombotic treatment in high-risk patients with atrial fibrillation: a
3376 report from the EORP-AF General Pilot Registry. *Europace* 2015;**17**:1777-1786.
- 3377 196. Freeman JV, Simon DN, Go AS, Spertus J, Fonarow GC, Gersh BJ, Hylek EM, Kowey PR,
3378 Mahaffey KW, Thomas LE, Chang P, Peterson ED, Piccini JP, Outcomes Registry for Better Informed
3379 Treatment of Atrial Fibrillation (ORBIT-AF) Investigators and Patients. Association Between Atrial
3380 Fibrillation Symptoms, Quality of Life, and Patient Outcomes: Results From the Outcomes Registry for
3381 Better Informed Treatment of Atrial Fibrillation (ORBIT-AF). *Circ Cardiovasc Qual Outcomes*
3382 2015;**8**:393-402.
- 3383 197. Boriani G, Laroche C, Diemberger I, Fantecchi E, Popescu MI, Rasmussen LH, Sinagra G,
3384 Petrescu L, Tavazzi L, Maggioni AP, Lip GY. Asymptomatic atrial fibrillation: clinical correlates,
3385 management, and outcomes in the EORP-AF Pilot General Registry. *Am J Med* 2015;**128**:509-518
3386 e502.
- 3387 198. Szymanski FM, Filipiak KJ, Karpinski G, Platek AE, Opolski G. Occurrence of poor sleep
3388 quality in atrial fibrillation patients according to the EHRA score. *Acta Cardiol* 2014;**69**:291-296.
- 3389 199. Wynn GJ, Todd DM, Webber M, Bonnett L, McShane J, Kirchhof P, Gupta D. The European
3390 Heart Rhythm Association symptom classification for atrial fibrillation: validation and improvement
3391 through a simple modification. *Europace* 2014;**16**:965-972.
- 3392 200. Meinertz T, Kirch W, Rosin L, Pittrow D, Willich SN, Kirchhof P, ATRIUM investigators.
3393 Management of atrial fibrillation by primary care physicians in Germany: baseline results of the
3394 ATRIUM registry. *Clin Res Cardiol* 2011;**100**:897-905.
- 3395 201. Nabauer M, Gerth A, Limbourg T, Schneider S, Oeff M, Kirchhof P, Goette A, Lewalter T,
3396 Ravens U, Meinertz T, Breithardt G, Steinbeck G. The Registry of the German Competence NETwork
3397 on Atrial Fibrillation: Patient characteristics and initial management. *Europace* 2009;**11**:423-434.
- 3398 202. von Eisenhart Rothe AF, Goette A, Kirchhof P, Breithardt G, Limbourg T, Calvert M, Baumert
3399 J, Ladwig KH. Depression in paroxysmal and persistent atrial fibrillation patients: a cross-sectional
3400 comparison of patients enrolled in two large clinical trials. *Europace* 2014;**16**:812-819.
- 3401 203. Pathak RK, Middeldorp ME, Lau DH, Mehta AB, Mahajan R, Twomey D, Alasady M, Hanley
3402 L, Antic NA, McEvoy RD, Kalman JM, Abhayaratna WP, Sanders P. Aggressive risk factor reduction
3403 study for atrial fibrillation and implications for the outcome of ablation: the ARREST-AF cohort study. *J*
3404 *Am Coll Cardiol* 2014;**64**:2222-2231.
- 3405 204. Abed HS, Wittert GA, Leong DP, Shirazi MG, Bahrami B, Middeldorp ME, Lorimer MF, Lau
3406 DH, Antic NA, Brooks AG, Abhayaratna WP, Kalman JM, Sanders P. Effect of weight reduction and
3407 cardiometabolic risk factor management on symptom burden and severity in patients with atrial
3408 fibrillation: a randomized clinical trial. *JAMA* 2013;**310**:2050-2060.
- 3409 205. Psaty BM, Manolio TA, Kuller LH, Kronmal RA, Cushman M, Fried LP, White R, Furberg CD,
3410 Rautaharju PM. Incidence of and risk factors for atrial fibrillation in older adults. *Circulation*
3411 1997;**96**:2455-2461.
- 3412 206. Selmer C, Olesen JB, Hansen ML, Lindhardsen J, Olsen AM, Madsen JC, Faber J, Hansen
3413 PR, Pedersen OD, Torp-Pedersen C, Gislason GH. The spectrum of thyroid disease and risk of new
3414 onset atrial fibrillation: a large population cohort study. *BMJ* 2012;**345**:e7895.
- 3415 207. Kim EJ, Lyass A, Wang N, Massaro JM, Fox CS, Benjamin EJ, Magnani JW. Relation of
3416 hypothyroidism and incident atrial fibrillation (from the Framingham Heart Study). *Am Heart J*
3417 2014;**167**:123-126.
- 3418 208. Vermond RA, Geelhoed B, Verweij N, Tieleman RG, Van der Harst P, Hillege HL, Van Gilst
3419 WH, Van Gelder IC, Rienstra M. Incidence of atrial fibrillation and relationship with cardiovascular
3420 events, heart failure, and mortality: A community-based study from the netherlands. *J Am Coll Cardiol*
3421 2015;**66**:1000-1007.
- 3422 209. Buch P, Friberg J, Scharling H, Lange P, Prescott E. Reduced lung function and risk of atrial
3423 fibrillation in the Copenhagen City Heart Study. *Eur Respir J* 2003;**21**:1012-1016.
- 3424 210. Gami AS, Hodge DO, Herges RM, Olson EJ, Nykodym J, Kara T, Somers VK. Obstructive
3425 sleep apnea, obesity, and the risk of incident atrial fibrillation. *J Am Coll Cardiol* 2007;**49**:565-571.
- 3426 211. Baber U, Howard VJ, Halperin JL, Soliman EZ, Zhang X, McClellan W, Warnock DG, Muntner
3427 P. Association of chronic kidney disease with atrial fibrillation among adults in the United States:
3428 REasons for Geographic and Racial Differences in Stroke (REGARDS) Study. *Circ Arrhythm*
3429 *Electrophysiol* 2011;**4**:26-32.
- 3430 212. Chamberlain AM, Agarwal SK, Folsom AR, Duval S, Soliman EZ, Ambrose M, Eberly LE,
3431 Alonso A. Smoking and incidence of atrial fibrillation: results from the Atherosclerosis Risk in
3432 Communities (ARIC) study. *Heart Rhythm* 2011;**8**:1160-1166.

- 3433 213. Larsson SC, Drca N, Wolk A. Alcohol consumption and risk of atrial fibrillation: a prospective
3434 study and dose-response meta-analysis. *J Am Coll Cardiol* 2014;**64**:281-289.
- 3435 214. Aizer A, Gaziano JM, Cook NR, Manson JE, Buring JE, Albert CM. Relation of vigorous
3436 exercise to risk of atrial fibrillation. *Am J Cardiol* 2009;**103**:1572-1577.
- 3437 215. Guha K, McDonagh T. Heart failure epidemiology: European perspective. *Curr Cardiol Rev*
3438 2013;**9**:123-127.
- 3439 216. Braunschweig F, Cowie MR, Auricchio A. What are the costs of heart failure? *Europace*
3440 2011;**13 Suppl 2**:ii13-17.
- 3441 217. Wodchis WP, Bhatia RS, Leblanc K, Meshkat N, Morra D. A review of the cost of atrial
3442 fibrillation. *Value Health* 2012;**15**:240-248.
- 3443 218. Kotecha D, Piccini JP. Atrial fibrillation in heart failure: what should we do? *Eur Heart J*
3444 2015;**36**:3250-3257.
- 3445 219. Olsson LG, Swedberg K, Ducharme A, Granger CB, Michelson EL, McMurray JJ, Puu M,
3446 Yusuf S, Pfeffer MA. Atrial fibrillation and risk of clinical events in chronic heart failure with and without
3447 left ventricular systolic dysfunction: results from the Candesartan in Heart failure-Assessment of
3448 Reduction in Mortality and morbidity (CHARM) program. *J Am Coll Cardiol* 2006;**47**:1997-2004.
- 3449 220. Kotecha D, Chudasama R, Lane DA, Kirchhof P, Lip GY. Atrial fibrillation and heart failure
3450 due to reduced versus preserved ejection fraction: A systematic review and meta-analysis of death
3451 and adverse outcomes. *Int J Cardiol* 2016;**203**:660-666.
- 3452 221. Mamas MA, Caldwell JC, Chacko S, Garratt CJ, Fath-Ordoubadi F, Neyses L. A meta-
3453 analysis of the prognostic significance of atrial fibrillation in chronic heart failure. *Eur J Heart Fail*
3454 2009;**11**:676-683.
- 3455 222. AUTHORS TO BE ADDED, The Task Force for the diagnosis and treatment of acute and
3456 chronic heart failure of the European Society of Cardiology (ESC). 2016 ESC Guidelines for the
3457 diagnosis and treatment of acute and chronic heart failure. *Eur Heart J* 2016.
- 3458 223. Lip GY, Heinzel FR, Gaita F, Juanatey JR, Le Heuzey JY, Potpara T, Svendsen JH, Vos MA,
3459 Anker SD, Coats AJ, Haverkamp W, Manolis AS, Chung MK, Sanders P, Pieske B, Gorenek B, Lane
3460 D, Boriani G, Linde C, Hindricks G, Tsutsui H, Homma S, Brownstein S, Nielsen JC, Lainscak M,
3461 Crespo-Leiro M, Piepoli M, Seferovic P, Savelieva I. European Heart Rhythm Association/Heart
3462 Failure Association joint consensus document on arrhythmias in heart failure, endorsed by the Heart
3463 Rhythm Society and the Asia Pacific Heart Rhythm Society. *Europace* 2016;**18**:12-36.
- 3464 224. McMurray JJ, Packer M, Desai AS, Gong J, Lefkowitz MP, Rizkala AR, Rouleau JL, Shi VC,
3465 Solomon SD, Swedberg K, Zile MR, PARADIGM-HF Investigators and Committees. Angiotensin-
3466 neprilysin inhibition versus enalapril in heart failure. *N Engl J Med* 2014;**371**:993-1004.
- 3467 225. Ziff OJ, Lane DA, Samra M, Griffith M, Kirchhof P, Lip GY, Steeds RP, Townend J, Kotecha
3468 D. Safety and efficacy of digoxin: systematic review and meta-analysis of observational and controlled
3469 trial data. *BMJ* 2015;**351**:h4451.
- 3470 226. Anselmino M, Matta M, D'Ascenzo F, Bunch TJ, Schilling RJ, Hunter RJ, Pappone C,
3471 Neumann T, Noelker G, Fiala M, Bertaglia E, Frontera A, Duncan E, Nalliah C, Jais P, Weerasooriya
3472 R, Kalman JM, Gaita F. Catheter ablation of atrial fibrillation in patients with left ventricular systolic
3473 dysfunction: a systematic review and meta-analysis. *Circ Arrhythm Electrophysiol* 2014;**7**:1011-1018.
- 3474 227. Ganesan AN, Nandal S, Luker J, Pathak RK, Mahajan R, Twomey D, Lau DH, Sanders P.
3475 Catheter ablation of atrial fibrillation in patients with concomitant left ventricular impairment: a
3476 systematic review of efficacy and effect on ejection fraction. *Heart Lung Circ* 2015;**24**:270-280.
- 3477 228. Khan MN, Jais P, Cummings J, Di Biase L, Sanders P, Martin DO, Kautzner J, Hao S,
3478 Themistoclakis S, Fanelli R, Potenza D, Massaro R, Wazni O, Schweikert R, Saliba W, Wang P, Al-
3479 Ahmad A, Beheiry S, Santarelli P, Starling RC, Dello Russo A, Pelargonio G, Brachmann J, Schibgilla
3480 V, Bonso A, Casella M, Raviele A, Haissaguerre M, Natale A, PABA-CHF Investigators. Pulmonary-
3481 vein isolation for atrial fibrillation in patients with heart failure. *N Engl J Med* 2008;**359**:1778-1785.
- 3482 229. Gupta S, Figueredo VM. Tachycardia mediated cardiomyopathy: pathophysiology,
3483 mechanisms, clinical features and management. *Int J Cardiol* 2014;**172**:40-46.
- 3484 230. Kusunose K, Yamada H, Nishio S, Tomita N, Niki T, Yamaguchi K, Koshiha K, Yagi S,
3485 Taketani Y, Iwase T, Soeki T, Wakatsuki T, Akaike M, Sata M. Clinical utility of single-beat E/e'
3486 obtained by simultaneous recording of flow and tissue Doppler velocities in atrial fibrillation with
3487 preserved systolic function. *JACC Cardiovasc Imaging* 2009;**2**:1147-1156.
- 3488 231. Li C, Zhang J, Zhou C, Huang L, Tang H, Rao L. Will simultaneous measurement of E/e'
3489 index facilitate the non-invasive assessment of left ventricular filling pressure in patients with non-
3490 valvular atrial fibrillation? *Eur J Echocardiogr* 2010;**11**:296-301.

- 3491 232. Senechal M, O'Connor K, Deblois J, Magne J, Dumesnil JG, Pibarot P, Bergeron S, Poirier P.
3492 A simple Doppler echocardiography method to evaluate pulmonary capillary wedge pressure in
3493 patients with atrial fibrillation. *Echocardiography* 2008;**25**:57-63.
- 3494 233. Sohn DW, Song JM, Zo JH, Chai IH, Kim HS, Chun HG, Kim HC. Mitral annulus velocity in
3495 the evaluation of left ventricular diastolic function in atrial fibrillation. *J Am Soc Echocardiogr*
3496 1999;**12**:927-931.
- 3497 234. Wada Y, Murata K, Tanaka T, Nose Y, Kihara C, Uchida K, Okuda S, Susa T, Kishida Y,
3498 Matsuzaki M. Simultaneous Doppler tracing of transmitral inflow and mitral annular velocity as an
3499 estimate of elevated left ventricular filling pressure in patients with atrial fibrillation. *Circ J*
3500 2012;**76**:675-681.
- 3501 235. Kelly JP, Mentz RJ, Mebazaa A, Voors AA, Butler J, Roessig L, Fiuzat M, Zannad F, Pitt B,
3502 O'Connor CM, Lam CS. Patient selection in heart failure with preserved ejection fraction clinical trials.
3503 *J Am Coll Cardiol* 2015;**65**:1668-1682.
- 3504 236. Schneider MP, Hua TA, Bohm M, Wachtell K, Kjeldsen SE, Schmieder RE. Prevention of
3505 atrial fibrillation by Renin-Angiotensin system inhibition a meta-analysis. *J Am Coll Cardiol*
3506 2010;**55**:2299-2307.
- 3507 237. Healey JS, Baranchuk A, Crystal E, Morillo CA, Garfinkle M, Yusuf S, Connolly SJ.
3508 Prevention of atrial fibrillation with angiotensin-converting enzyme inhibitors and angiotensin receptor
3509 blockers: a meta-analysis. *J Am Coll Cardiol* 2005;**45**:1832-1839.
- 3510 238. Jibrini MB, Molnar J, Arora RR. Prevention of atrial fibrillation by way of abrogation of the
3511 renin-angiotensin system: a systematic review and meta-analysis. *Am J Ther* 2008;**15**:36-43.
- 3512 239. Ducharme A, Swedberg K, Pfeffer MA, Cohen-Solal A, Granger CB, Maggioni AP, Michelson
3513 EL, McMurray JJ, Olsson L, Rouleau JL, Young JB, Olofsson B, Pua M, Yusuf S, CHARM
3514 Investigators. Prevention of atrial fibrillation in patients with symptomatic chronic heart failure by
3515 candesartan in the Candesartan in Heart failure: Assessment of Reduction in Mortality and morbidity
3516 (CHARM) program. *Am Heart J* 2006;**152**:86-92.
- 3517 240. GISSI-AF Investigators, Disertori M, Latini R, Barlera S, Franzosi MG, Staszewsky L,
3518 Maggioni AP, Lucci D, Di Pasquale G, Tognoni G. Valsartan for prevention of recurrent atrial
3519 fibrillation. *N Engl J Med* 2009;**360**:1606-1617.
- 3520 241. Goette A, Schon N, Kirchhof P, Breithardt G, Fetsch T, Hausler KG, Klein HU, Steinbeck G,
3521 Wegscheider K, Meinertz T. Angiotensin II-antagonist in paroxysmal atrial fibrillation (ANTIPAF) trial.
3522 *Circ Arrhythm Electrophysiol* 2012;**5**:43-51.
- 3523 242. Active I Investigators, Yusuf S, Healey JS, Pogue J, Chrolavicius S, Flather M, Hart RG,
3524 Hohnloser SH, Joyner CD, Pfeffer MA, Connolly SJ. Irbesartan in patients with atrial fibrillation. *N*
3525 *Engl J Med* 2011;**364**:928-938.
- 3526 243. Swedberg K, Zannad F, McMurray JJ, Krum H, van Veldhuisen DJ, Shi H, Vincent J, Pitt B.
3527 Eplerenone and atrial fibrillation in mild systolic heart failure: results from the EMPHASIS-HF
3528 (Eplerenone in Mild Patients Hospitalization And Survival Study in Heart Failure) study. *J Am Coll*
3529 *Cardiol* 2012;**59**:1598-1603.
- 3530 244. Goette A, Staack T, Rocken C, Arndt M, Geller JC, Huth C, Ansoerge S, Klein HU, Lendeckel
3531 U. Increased expression of extracellular signal-regulated kinase and angiotensin-converting enzyme
3532 in human atria during atrial fibrillation. *J Am Coll Cardiol* 2000;**35**:1669-1677.
- 3533 245. Marott SC, Nielsen SF, Benn M, Nordestgaard BG. Antihypertensive treatment and risk of
3534 atrial fibrillation: a nationwide study. *Eur Heart J* 2014;**35**:1205-1214.
- 3535 246. Wachtell K, Lehto M, Gerds E, Olsen MH, Hornestam B, Dahlof B, Ibsen H, Julius S,
3536 Kjeldsen SE, Lindholm LH, Nieminen MS, Devereux RB. Angiotensin II receptor blockade reduces
3537 new-onset atrial fibrillation and subsequent stroke compared to atenolol: the Losartan Intervention For
3538 End Point Reduction in Hypertension (LIFE) study. *J Am Coll Cardiol* 2005;**45**:712-719.
- 3539 247. Manolis AJ, Rosei EA, Coca A, Cifkova R, Erdine SE, Kjeldsen S, Lip GY, Narkiewicz K,
3540 Parati G, Redon J, Schmieder R, Tsioufis C, Mancia G. Hypertension and atrial fibrillation: diagnostic
3541 approach, prevention and treatment. Position paper of the Working Group 'Hypertension Arrhythmias
3542 and Thrombosis' of the European Society of Hypertension. *J Hypertens* 2012;**30**:239-252.
- 3543 248. Madrid AH, Bueno MG, Rebollo JM, Marin I, Pena G, Bernal E, Rodriguez A, Cano L, Cano
3544 JM, Cabeza P, Moro C. Use of irbesartan to maintain sinus rhythm in patients with long-lasting
3545 persistent atrial fibrillation: a prospective and randomized study. *Circulation* 2002;**106**:331-336.
- 3546 249. Ueng K-C, Tsai T-P, Yu W-C, Tsai C-F, Lin M-C, Chan K-C, Chen C-Y, Wu D-J, Lin C-S,
3547 Chen S-A. Use of enalapril to facilitate sinus rhythm maintenance after external cardioversion of long-
3548 standing persistent atrial fibrillation. Results of a prospective and controlled study. *Eur Heart J*
3549 2003;**24**:2090-2098.

- 3550 250. Anand K, Mooss AN, Hee TT, Mohiuddin SM. Meta-analysis: inhibition of renin-angiotensin
3551 system prevents new-onset atrial fibrillation. *Am Heart J* 2006;**152**:217-222.
- 3552 251. Tveit A, Seljeflot I, Grundvold I, Abdelnoor M, Smith P, Arnesen H. Effect of candesartan and
3553 various inflammatory markers on maintenance of sinus rhythm after electrical cardioversion for atrial
3554 fibrillation. *Am J Cardiol* 2007;**99**:1544-1548.
- 3555 252. Furberg CD, Psaty BM, Manolio TA, Gardin JM, Smith VE, Rautaharju PM. Prevalence of
3556 atrial fibrillation in elderly subjects (the Cardiovascular Health Study). *Am J Cardiol* 1994;**74**:236-241.
- 3557 253. Vahanian A, Alfieri O, Andreotti F, Antunes MJ, Baron-Esquivias G, Baumgartner H, Borger
3558 MA, Carrel TP, De Bonis M, Evangelista A, Falk V, Jung B, Lancellotti P, Pierard L, Price S, Schafers
3559 HJ, Schuler G, Stepinska J, Swedberg K, Takkenberg J, Von Oppell UO, Windecker S, Zamorano JL,
3560 Zembala M, Joint Task Force on the Management of Valvular Heart Disease of the European Society
3561 of Cardiology (ESC), European Association for Cardio-Thoracic Surgery (EACTS). Guidelines on the
3562 management of valvular heart disease (version 2012). *Eur Heart J* 2012;**33**:2451-2496.
- 3563 254. Nishimura RA, Otto CM, Bonow RO, Carabello BA, Erwin JP, 3rd, Guyton RA, O'Gara PT,
3564 Ruiz CE, Skubas NJ, Sorajja P, Sundt TM, 3rd, Thomas JD. 2014 AHA/ACC guideline for the
3565 management of patients with valvular heart disease: executive summary: a report of the American
3566 College of Cardiology/American Heart Association Task Force on Practice Guidelines. *J Am Coll*
3567 *Cardiol* 2014;**63**:2438-2488.
- 3568 255. Nieuwlaat R, Capucci A, Camm AJ, Olsson SB, Andresen D, Davies DW, Cobbe S, Breithardt
3569 G, Le Heuzey JY, Prins MH, Levy S, Crijns HJ. Atrial fibrillation management: a prospective survey in
3570 ESC member countries: the Euro Heart Survey on Atrial Fibrillation. *Eur Heart J* 2005;**26**:2422-2434.
- 3571 256. Moretti M, Fabris E, Morosin M, Merlo M, Barbati G, Pinamonti B, Gatti G, Pappalardo A,
3572 Sinagra G. Prognostic significance of atrial fibrillation and severity of symptoms of heart failure in
3573 patients with low gradient aortic stenosis and preserved left ventricular ejection fraction. *Am J Cardiol*
3574 2014;**114**:1722-1728.
- 3575 257. Ngaage DL, Schaff HV, Mullany CJ, Barnes S, Dearani JA, Daly RC, Orszulak TA, Sundt TM,
3576 3rd. Influence of preoperative atrial fibrillation on late results of mitral repair: is concomitant ablation
3577 justified? *Ann Thorac Surg* 2007;**84**:434-442; discussion 442-433.
- 3578 258. Ngaage DL, Schaff HV, Barnes SA, Sundt TM, 3rd, Mullany CJ, Dearani JA, Daly RC,
3579 Orszulak TA. Prognostic implications of preoperative atrial fibrillation in patients undergoing aortic
3580 valve replacement: is there an argument for concomitant arrhythmia surgery? *Ann Thorac Surg*
3581 2006;**82**:1392-1399.
- 3582 259. Eguchi K, Ohtaki E, Matsumura T, Tanaka K, Tohbaru T, Iguchi N, Misu K, Asano R,
3583 Nagayama M, Sumiyoshi T, Kasegawa H, Hosoda S. Pre-operative atrial fibrillation as the key
3584 determinant of outcome of mitral valve repair for degenerative mitral regurgitation. *Eur Heart J*
3585 2005;**26**:1866-1872.
- 3586 260. Lim E, Barlow CW, Hosseinpour AR, Wisbey C, Wilson K, Pidgeon W, Charman S, Barlow
3587 JB, Wells FC. Influence of atrial fibrillation on outcome following mitral valve repair. *Circulation*
3588 2001;**104**:159-63.
- 3589 261. Maan A, Heist EK, Passeri J, Inglessis I, Baker J, Ptaszek L, Vlahakes G, Ruskin JN,
3590 Palacios I, Sundt T, Mansour M. Impact of atrial fibrillation on outcomes in patients who underwent
3591 transcatheter aortic valve replacement. *Am J Cardiol* 2015;**115**:220-226.
- 3592 262. Barbash IM, Minha S, Ben-Dor I, Dvir D, Torguson R, Aly M, Bond E, Satler LF, Pichard AD,
3593 Waksman R. Predictors and clinical implications of atrial fibrillation in patients with severe aortic
3594 stenosis undergoing transcatheter aortic valve implantation. *Catheter Cardiovasc Interv* 2015;**85**:468-
3595 477.
- 3596 263. Halperin JL, Hart RG. Atrial fibrillation and stroke: new ideas, persisting dilemmas. *Stroke*
3597 1988;**19**:937-941.
- 3598 264. Messika-Zeitoun D, Bellamy M, Avierinos JF, Breen J, Eusemann C, Rossi A, Behrenbeck T,
3599 Scott C, Tajik JA, Enriquez-Sarano M. Left atrial remodelling in mitral regurgitation--methodologic
3600 approach, physiological determinants, and outcome implications: a prospective quantitative Doppler-
3601 echocardiographic and electron beam-computed tomographic study. *Eur Heart J* 2007;**28**:1773-1781.
- 3602 265. Calvo N, Bisbal F, Guiu E, Ramos P, Nadal M, Tolosana JM, Arbelo E, Berruezo A, Sitges M,
3603 Brugada J, Mont L. Impact of atrial fibrillation-induced tachycardiomyopathy in patients undergoing
3604 pulmonary vein isolation. *Int J Cardiol* 2013;**168**:4093-4097.
- 3605 266. Edner M, Caidahl K, Bergfeldt L, Darpo B, Edvardsson N, Rosenqvist M. Prospective study of
3606 left ventricular function after radiofrequency ablation of atrioventricular junction in patients with atrial
3607 fibrillation. *Br Heart J* 1995;**74**:261-267.

- 3608 267. Gertz ZM, Raina A, Saghy L, Zado ES, Callans DJ, Marchlinski FE, Keane MG, Silvestry FE.
3609 Evidence of atrial functional mitral regurgitation due to atrial fibrillation: reversal with arrhythmia
3610 control. *J Am Coll Cardiol* 2011;**58**:1474-1481.
- 3611 268. Kihara T, Gillinov AM, Takasaki K, Fukuda S, Song JM, Shiota M, Shiota T. Mitral
3612 regurgitation associated with mitral annular dilation in patients with lone atrial fibrillation: an
3613 echocardiographic study. *Echocardiography* 2009;**26**:885-889.
- 3614 269. Zhou X, Otsuji Y, Yoshifuku S, Yuasa T, Zhang H, Takasaki K, Matsukida K, Kisanuki A,
3615 Minagoe S, Tei C. Impact of atrial fibrillation on tricuspid and mitral annular dilatation and valvular
3616 regurgitation. *Circ J* 2002;**66**:913-916.
- 3617 270. Ring L, Dutka DP, Wells FC, Fynn SP, Shapiro LM, Rana BS. Mechanisms of atrial mitral
3618 regurgitation: insights using 3D transoesophageal echo. *Eur Heart J Cardiovasc Imaging*
3619 2014;**15**:500-508.
- 3620 271. Vahanian A, Alfieri O, Andreotti F, Antunes MJ, Baron-Esquivias G, Baumgartner H, Borger
3621 MA, Carrel TP, De Bonis M, Evangelista A, Falk V, Lung B, Lancellotti P, Pierard L, Price S, Schafers
3622 HJ, Schuler G, Stepinska J, Swedberg K, Takkenberg J, Von Oppell UO, Windecker S, Zamorano JL,
3623 Zembala M, ESC Committee for Practice Guidelines (CPG), Joint Task Force on the Management of
3624 Valvular Heart Disease of the European Society of Cardiology (ESC), European Association for
3625 Cardio-Thoracic Surgery (EACTS). Guidelines on the management of valvular heart disease (version
3626 2012): the Joint Task Force on the Management of Valvular Heart Disease of the European Society of
3627 Cardiology (ESC) and the European Association for Cardio-Thoracic Surgery (EACTS). *Eur J*
3628 *Cardiothorac Surg* 2012;**42**:S1-44.
- 3629 272. Molteni M, Polo Friz H, Primitz L, Marano G, Boracchi P, Cimminiello C. The definition of
3630 valvular and non-valvular atrial fibrillation: results of a physicians' survey. *Europace* 2014;**16**:1720-
3631 1725.
- 3632 273. Blackshear JL, Odell JA. Appendage obliteration to reduce stroke in cardiac surgical patients
3633 with atrial fibrillation. *Ann Thorac Surg* 1996;**61**:755-759.
- 3634 274. Szekely P. Systemic Embolism and Anticoagulant Prophylaxis in Rheumatic Heart Disease.
3635 *Br Med J* 1964;**1**:1209-1212.
- 3636 275. De Caterina R, Camm AJ. What is 'valvular' atrial fibrillation? A reappraisal. *Eur Heart J*
3637 2014;**35**:3328-3335.
- 3638 276. Goldstone AB, Patrick WL, Cohen JE, Aribeara CN, Popat R, Woo YJ. Early surgical
3639 intervention or watchful waiting for the management of asymptomatic mitral regurgitation: a
3640 systematic review and meta-analysis. *Ann Cardiothorac Surg* 2015;**4**:220-229.
- 3641 277. Schoen T, Pradhan AD, Albert CM, Conen D. Type 2 diabetes mellitus and risk of incident
3642 atrial fibrillation in women. *J Am Coll Cardiol* 2012;**60**:1421-1428.
- 3643 278. Du X, Ninomiya T, de Galan B, Abadir E, Chalmers J, Pillai A, Woodward M, Cooper M,
3644 Harrap S, Hamet P, Poulter N, Lip GY, Patel A. Risks of cardiovascular events and effects of routine
3645 blood pressure lowering among patients with type 2 diabetes and atrial fibrillation: results of the
3646 ADVANCE study. *Eur Heart J* 2009;**30**:1128-1135.
- 3647 279. Rizzo MR, Sasso FC, Marfella R, Siniscalchi M, Paolisso P, Carbonara O, Capoluongo MC,
3648 Lascar N, Pace C, Sardu C, Passavanti B, Barbieri M, Mauro C, Paolisso G. Autonomic dysfunction is
3649 associated with brief episodes of atrial fibrillation in type 2 diabetes. *J Diabetes Complications*
3650 2015;**29**:88-92.
- 3651 280. Olson TM, Terzic A. Human K(ATP) channelopathies: diseases of metabolic homeostasis.
3652 *Pflugers Arch* 2010;**460**:295-306.
- 3653 281. Chung MK, Martin DO, Sprecher D, Wazni O, Kanderian A, Carnes CA, Bauer JA, Tchou PJ,
3654 Niebauer MJ, Natale A, Van Wagoner DR. C-reactive protein elevation in patients with atrial
3655 arrhythmias: inflammatory mechanisms and persistence of atrial fibrillation. *Circulation*
3656 2001;**104**:2886-2891.
- 3657 282. Donath MY, Shoelson SE. Type 2 diabetes as an inflammatory disease. *Nat Rev Immunol*
3658 2011;**11**:98-107.
- 3659 283. Ziolo MT, Mohler PJ. Defining the role of oxidative stress in atrial fibrillation and diabetes. *J*
3660 *Cardiovasc Electrophysiol* 2015;**26**:223-225.
- 3661 284. Fatemi O, Yuriditsky E, Tsioufis C, Tsachris D, Morgan T, Basile J, Bigger T, Cushman W,
3662 Goff D, Soliman EZ, Thomas A, Papademetriou V. Impact of intensive glycemic control on the
3663 incidence of atrial fibrillation and associated cardiovascular outcomes in patients with type 2 diabetes
3664 mellitus (from the Action to Control Cardiovascular Risk in Diabetes Study). *Am J Cardiol*
3665 2014;**114**:1217-1222.

- 3666 285. Overvad TF, Skjoth F, Lip GY, Lane DA, Albertsen IE, Rasmussen LH, Larsen TB. Duration
3667 of Diabetes Mellitus and Risk of Thromboembolism and Bleeding in Atrial Fibrillation: Nationwide
3668 Cohort Study. *Stroke* 2015;**46**:2168-2174.
- 3669 286. Chang S-H, Wu L-S, Chiou M-J, Liu J-R, Yu K-H, Kuo C-F, Wen M-S, Chen W-J, Yeh Y-H,
3670 See L-C. Association of metformin with lower atrial fibrillation risk among patients with type 2 diabetes
3671 mellitus: a population-based dynamic cohort and in vitro studies. *Cardiovasc Diabetol* 2014;**13**:123.
- 3672 287. Lip GY, Clementy N, Pierre B, Boyer M, Fauchier L. The impact of associated diabetic
3673 retinopathy on stroke and severe bleeding risk in diabetic patients with atrial fibrillation: the Loire
3674 valley atrial fibrillation project. *Chest* 2015;**147**:1103-1110.
- 3675 288. Huxley RR, Misialek JR, Agarwal SK, Loehr LR, Soliman EZ, Chen LY, Alonso A. Physical
3676 activity, obesity, weight change, and risk of atrial fibrillation: the Atherosclerosis Risk in Communities
3677 study. *Circ Arrhythm Electrophysiol* 2014;**7**:620-625.
- 3678 289. Murphy NF, MacIntyre K, Stewart S, Hart CL, Hole D, McMurray JJ. Long-term cardiovascular
3679 consequences of obesity: 20-year follow-up of more than 15 000 middle-aged men and women (the
3680 Renfrew-Paisley study). *Eur Heart J* 2006;**27**:96-106.
- 3681 290. Wanahita N, Messerli FH, Bangalore S, Gami AS, Somers VK, Steinberg JS. Atrial fibrillation
3682 and obesity--results of a meta-analysis. *Am Heart J* 2008;**155**:310-315.
- 3683 291. Wang TJ, Parise H, Levy D, D'Agostino RB, Sr., Wolf PA, Vasan RS, Benjamin EJ. Obesity
3684 and the risk of new-onset atrial fibrillation. *JAMA* 2004;**292**:2471-2477.
- 3685 292. Overvad TF, Rasmussen LH, Skjoth F, Overvad K, Lip GY, Larsen TB. Body mass index and
3686 adverse events in patients with incident atrial fibrillation. *Am J Med* 2013;**126**:640.e649-617.
- 3687 293. Karason K, Molgaard H, Wikstrand J, Sjoström L. Heart rate variability in obesity and the
3688 effect of weight loss. *Am J Cardiol* 1999;**83**:1242-1247.
- 3689 294. Russo C, Jin Z, Homma S, Rundek T, Elkind MS, Sacco RL, Di Tullio MR. Effect of obesity
3690 and overweight on left ventricular diastolic function: a community-based study in an elderly cohort. *J
3691 Am Coll Cardiol* 2011;**57**:1368-1374.
- 3692 295. Visser M, Bouter LM, McQuillan GM, Wener MH, Harris TB. Elevated C-reactive protein levels
3693 in overweight and obese adults. *Jama* 1999;**282**:2131-2135.
- 3694 296. Pathak RK, Middeldorp ME, Meredith M, Mehta AB, Mahajan R, Wong CX, Twomey D, Elliott
3695 AD, Kalman JM, Abhayaratna WP, Lau DH, Sanders P. Long-Term Effect of Goal-Directed Weight
3696 Management in an Atrial Fibrillation Cohort: A Long-Term Follow-Up Study (LEGACY). *J Am Coll
3697 Cardiol* 2015;**65**:2159-2169.
- 3698 297. Pathak RK, Elliott A, Middeldorp ME, Meredith M, Mehta AB, Mahajan R, Hendriks JM,
3699 Twomey D, Kalman JM, Abhayaratna WP, Lau DH, Sanders P. Impact of CARDIOrespiratory FITness
3700 on Arrhythmia Recurrence in Obese Individuals With Atrial Fibrillation: The CARDIO-FIT Study. *J Am
3701 Coll Cardiol* 2015;**66**:985-996.
- 3702 298. Cha YM, Friedman PA, Asirvatham SJ, Shen WK, Munger TM, Rea RF, Brady PA, Jahangir
3703 A, Monahan KH, Hodge DO, Meverden RA, Gersh BJ, Hammill SC, Packer DL. Catheter ablation for
3704 atrial fibrillation in patients with obesity. *Circulation* 2008;**117**:2583-2590.
- 3705 299. Jongnarangsin K, Chugh A, Good E, Mukerji S, Dey S, Crawford T, Sarrazin JF, Kuhne M,
3706 Chalfoun N, Wells D, Boonyapisit W, Pelosi F, Jr., Bogun F, Morady F, Oral H. Body mass index,
3707 obstructive sleep apnea, and outcomes of catheter ablation of atrial fibrillation. *J Cardiovasc
3708 Electrophysiol* 2008;**19**:668-672.
- 3709 300. Guijian L, Jinchuan Y, Rongzeng D, Jun Q, Jun W, Wenqing Z. Impact of body mass index on
3710 atrial fibrillation recurrence: a meta-analysis of observational studies. *Pacing Clin Electrophysiol*
3711 2013;**36**:748-756.
- 3712 301. Zhuang J, Lu Y, Tang K, Peng W, Xu Y. Influence of body mass index on recurrence and
3713 quality of life in atrial fibrillation patients after catheter ablation: a meta-analysis and systematic
3714 review. *Clin Cardiol* 2013;**36**:269-275.
- 3715 302. Ector J, Dragusin O, Adriaenssens B, Huybrechts W, Willems R, Ector H, Heidbuchel H.
3716 Obesity is a major determinant of radiation dose in patients undergoing pulmonary vein isolation for
3717 atrial fibrillation. *J Am Coll Cardiol* 2007;**50**:234-242.
- 3718 303. Shoemaker MB, Muhammad R, Farrell M, Parvez B, White BW, Streur M, Stubblefield T,
3719 Rytlewski J, Parvathaneni S, Nagarakanti R, Roden DM, Saavedra P, Ellis C, Whalen SP, Darbar D.
3720 Relation of morbid obesity and female gender to risk of procedural complications in patients
3721 undergoing atrial fibrillation ablation. *Am J Cardiol* 2013;**111**:368-373.
- 3722 304. Vizzard E, Sciatti E, Bonadei I, D'Aloia A, Curnis A, Metra M. Obstructive sleep apnoea-
3723 hypopnoea and arrhythmias: new updates. *J Cardiovasc Med (Hagerstown)* 2014.
- 3724 305. Digby GC, Baranchuk A. Sleep apnea and atrial fibrillation; 2012 update. *Curr Cardiol Rev*
3725 2012;**8**:265-272.

- 3726 306. Lin YK, Lai MS, Chen YC, Cheng CC, Huang JH, Chen SA, Chen YJ, Lin CI. Hypoxia and
3727 reoxygenation modulate the arrhythmogenic activity of the pulmonary vein and atrium. *Clin Sci (Lond)*
3728 2012;**122**:121-132.
- 3729 307. Linz D. Atrial fibrillation in obstructive sleep apnea: atrial arrhythmogenic substrate of a
3730 different sort. *Am J Cardiol* 2012;**110**:1071.
- 3731 308. Patel D, Mohanty P, Di Biase L, Shaheen M, Lewis WR, Quan K, Cummings JE, Wang P, Al-
3732 Ahmad A, Venkatraman P, Nashawati E, Lakkireddy D, Schweikert R, Horton R, Sanchez J,
3733 Gallinghouse J, Hao S, Beheiry S, Cardinal DS, Zagrodzky J, Canby R, Bailey S, Burkhardt JD,
3734 Natale A. Safety and efficacy of pulmonary vein antral isolation in patients with obstructive sleep
3735 apnea: the impact of continuous positive airway pressure. *Circ Arrhythm Electrophysiol* 2010;**3**:445-
3736 451.
- 3737 309. Fein AS, Shvilkin A, Shah D, Haffajee CI, Das S, Kumar K, Kramer DB, Zimetbaum PJ,
3738 Buxton AE, Josephson ME, Anter E. Treatment of obstructive sleep apnea reduces the risk of atrial
3739 fibrillation recurrence after catheter ablation. *J Am Coll Cardiol* 2013;**62**:300-305.
- 3740 310. Naruse Y, Tada H, Satoh M, Yanagihara M, Tsuneoka H, Hirata Y, Ito Y, Kuroki K, Machino
3741 T, Yamasaki H, Igarashi M, Sekiguchi Y, Sato A, Aonuma K. Concomitant obstructive sleep apnea
3742 increases the recurrence of atrial fibrillation following radiofrequency catheter ablation of atrial
3743 fibrillation: clinical impact of continuous positive airway pressure therapy. *Heart Rhythm* 2013;**10**:331-
3744 337.
- 3745 311. Neilan TG, Farhad H, Dodson JA, Shah RV, Abbasi SA, Bakker JP, Michaud GF, van der
3746 Geest R, Blankstein R, Steigner M, John RM, Jerosch-Herold M, Malhotra A, Kwong RY. Effect of
3747 sleep apnea and continuous positive airway pressure on cardiac structure and recurrence of atrial
3748 fibrillation. *J Am Heart Assoc* 2013;**2**:e000421.
- 3749 312. Li L, Wang ZW, Li J, Ge X, Guo LZ, Wang Y, Guo WH, Jiang CX, Ma CS. Efficacy of catheter
3750 ablation of atrial fibrillation in patients with obstructive sleep apnoea with and without continuous
3751 positive airway pressure treatment: a meta-analysis of observational studies. *Europace*
3752 2014;**16**:1309-1314.
- 3753 313. Cowie MR, Woehrle H, Wegscheider K, Angermann C, d'Ortho MP, Erdmann E, Levy P,
3754 Simonds AK, Somers VK, Zannad F, Teschler H. Adaptive Servo-Ventilation for Central Sleep Apnea
3755 in Systolic Heart Failure. *N Engl J Med* 2015;**373**:1095-1105.
- 3756 314. Bitter T, Nolker G, Vogt J, Prinz C, Horstkotte D, Oldenburg O. Predictors of recurrence in
3757 patients undergoing cryoballoon ablation for treatment of atrial fibrillation: the independent role of
3758 sleep-disordered breathing. *J Cardiovasc Electrophysiol* 2012;**23**:18-25.
- 3759 315. Ng CY, Liu T, Shehata M, Stevens S, Chugh SS, Wang X. Meta-analysis of obstructive sleep
3760 apnea as predictor of atrial fibrillation recurrence after catheter ablation. *Am J Cardiol* 2011;**108**:47-
3761 51.
- 3762 316. Hart RG, Eikelboom JW, Brimble KS, McMurry MS, Ingram AJ. Stroke prevention in atrial
3763 fibrillation patients with chronic kidney disease. *Can J Cardiol* 2013;**29**:S71-78.
- 3764 317. Roldan V, Marin F, Fernandez H, Manzano-Fernandez S, Gallego P, Valdes M, Vicente V, Lip
3765 GY. Renal impairment in a "real-life" cohort of anticoagulated patients with atrial fibrillation
3766 (implications for thromboembolism and bleeding). *Am J Cardiol* 2013;**111**:1159-1164.
- 3767 318. Connolly SJ, Ezekowitz MD, Yusuf S, Eikelboom J, Oldgren J, Parekh A, Pogue J, Reilly PA,
3768 Themeles E, Varrone J, Wang S, Alings M, Xavier D, Zhu J, Diaz R, Lewis BS, Darius H, Diener HC,
3769 Joyner CD, Wallentin L, RE-LY Steering Committee and Investigators. Dabigatran versus warfarin in
3770 patients with atrial fibrillation. *N Engl J Med* 2009;**361**:1139-1151.
- 3771 319. Granger CB, Alexander JH, McMurray JJ, Lopes RD, Hylek EM, Hanna M, Al-Khalidi HR,
3772 Ansell J, Atar D, Avezum A, Bahit MC, Diaz R, Easton JD, Ezekowitz JA, Flaker G, Garcia D,
3773 Geraldes M, Gersh BJ, Golitsyn S, Goto S, Hermosillo AG, Hohnloser SH, Horowitz J, Mohan P,
3774 Jansky P, Lewis BS, Lopez-Sendon JL, Pais P, Parkhomenko A, Verheugt FW, Zhu J, Wallentin L,
3775 ARISTOTLE Committees and Investigators. Apixaban versus warfarin in patients with atrial fibrillation.
3776 *N Engl J Med* 2011;**365**:981-992.
- 3777 320. Patel MR, Mahaffey KW, Garg J, Pan G, Singer DE, Hacke W, Breithardt G, Halperin JL,
3778 Hankey GJ, Piccini JP, Becker RC, Nessel CC, Paolini JF, Berkowitz SD, Fox KA, Califf RM,
3779 ROCKET AF Investigators. Rivaroxaban versus warfarin in nonvalvular atrial fibrillation. *N Engl J Med*
3780 2011;**365**:883-891.
- 3781 321. Giugliano RP, Ruff CT, Braunwald E, Murphy SA, Wiviott SD, Halperin JL, Waldo AL,
3782 Ezekowitz MD, Weitz JI, Spinar J, Ruzyllo W, Ruda M, Koretsune Y, Betcher J, Shi M, Grip LT, Patel
3783 SP, Patel I, Hanyok JJ, Mercuri M, Antman EM, Investigators EA-T. Edoxaban versus warfarin in
3784 patients with atrial fibrillation. *N Engl J Med* 2013;**369**:2093-2104.

- 3785 322. Page K, Marwick TH, Lee R, Grenfell R, Abhayaratna WP, Aggarwal A, Briffa TG, Cameron J,
3786 Davidson PM, Driscoll A, Garton-Smith J, Gascard DJ, Hickey A, Korczyk D, Mitchell JA, Sanders R,
3787 Spicer D, Stewart S, Wade V. A systematic approach to chronic heart failure care: a consensus
3788 statement. *Med J Aust* 2014;**201**:146-150.
- 3789 323. Stock S, Pitcavage JM, Simic D, Altin S, Graf C, Feng W, Graf TR. Chronic care model
3790 strategies in the United States and Germany deliver patient-centered, high-quality diabetes care.
3791 *Health Aff (Millwood)* 2014;**33**:1540-1548.
- 3792 324. Lundstrom H, Siersma V, Nielsen AB, Brodersen J, Reventlow S, Andersen PK, de Fine
3793 Olivarius N. The effectiveness of structured personal care of type 2 diabetes on recurrent outcomes: a
3794 19 year follow-up of the study Diabetes Care in General Practice (DCGP). *Diabetologia*
3795 2014;**57**:1119-1123.
- 3796 325. Berti D, Hendriks JM, Brandes A, Deaton C, Crijns HJ, Camm AJ, Hindricks G, Moons P,
3797 Heidebuchel H. A proposal for interdisciplinary, nurse-coordinated atrial fibrillation expert programmes
3798 as a way to structure daily practice. *Eur Heart J* 2013;**34**:2725-2730.
- 3799 326. Wagner EH, Austin BT, Von Korff M. Organizing care for patients with chronic illness. *Milbank*
3800 *Q* 1996;**74**:511-544.
- 3801 327. Nieuwlaat R, Olsson SB, Lip GY, Camm AJ, Breithardt G, Capucci A, Meeder JG, Prins MH,
3802 Levy S, Crijns HJ, Euro Heart Survey Investigators. Guideline-adherent antithrombotic treatment is
3803 associated with improved outcomes compared with undertreatment in high-risk patients with atrial
3804 fibrillation. The Euro Heart Survey on Atrial Fibrillation. *Am Heart J* 2007;**153**:1006-1012.
- 3805 328. Nuno R, Coleman K, Bengoa R, Sauto R. Integrated care for chronic conditions: the
3806 contribution of the ICCF Framework. *Health Policy* 2012;**105**:55-64.
- 3807 329. Kirchhof P, Nabauer M, Gerth A, Limbourg T, Lewalter T, Goette A, Wegscheider K, Treszl A,
3808 Meinertz T, Oeff M, Ravens U, Breithardt G, Steinbeck G. Impact of the type of centre on
3809 management of AF patients: surprising evidence for differences in antithrombotic therapy decisions.
3810 *Thromb Haemost* 2011;**105**:1010-1023.
- 3811 330. Hendriks JM, de Wit R, Crijns HJ, Vrijhoef HJ, Prins MH, Pisters R, Pison LA, Blaauw Y,
3812 Tieleman RG. Nurse-led care vs. usual care for patients with atrial fibrillation: results of a randomized
3813 trial of integrated chronic care vs. routine clinical care in ambulatory patients with atrial fibrillation. *Eur*
3814 *Heart J* 2012;**33**:2692-2699.
- 3815 331. Hendriks J, Tomini F, van Asselt T, Crijns H, Vrijhoef H. Cost-effectiveness of a specialized
3816 atrial fibrillation clinic vs. usual care in patients with atrial fibrillation. *Europace* 2013;**15**:1128-1135.
- 3817 332. Stewart S, Ball J, Horowitz JD, Marwick TH, Mahadevan G, Wong C, Abhayaratna WP, Chan
3818 YK, Esterman A, Thompson DR, Scuffham PA, Carrington MJ. Standard versus atrial fibrillation-
3819 specific management strategy (SAFETY) to reduce recurrent admission and prolong survival:
3820 pragmatic, multicentre, randomised controlled trial. *Lancet* 2015;**385**:775-784.
- 3821 333. Tran HN, Tafreshi J, Hernandez EA, Pai SM, Torres VI, Pai RG. A multidisciplinary atrial
3822 fibrillation clinic. *Curr Cardiol Rev* 2013;**9**:55-62.
- 3823 334. Conti A, Canuti E, Mariannini Y, Viviani G, Poggioni C, Boni V, Pini R, Vanni S, Padeletti L,
3824 Gensini GF. Clinical management of atrial fibrillation: early interventions, observation, and structured
3825 follow-up reduce hospitalizations. *Am J Emerg Med* 2012;**30**:1962-1969.
- 3826 335. Carter L, Gardner M, Magee K, Fearon A, Morgulis I, Doucette S, Sapp JL, Gray C,
3827 Abdelwahab A, Parkash R. An Integrated Management Approach to Atrial Fibrillation. *J Am Heart*
3828 *Assoc* 2016;**5**:e002950.
- 3829 336. Peterson ED, Ho PM, Barton M, Beam C, Burgess LH, Casey DE, Jr., Drozda JP, Jr.,
3830 Fonarow GC, Goff D, Jr., Grady KL, King DE, King ML, Masoudi FA, Nielsen DR, Stanko S.
3831 ACC/AHA/AACVPR/AAFP/ANA Concepts for Clinician-Patient Shared Accountability in Performance
3832 Measures: A Report of the American College of Cardiology/American Heart Association Task Force
3833 on Performance Measures. *Circulation* 2014.
- 3834 337. Lane DA, Aguinaga L, Blomstrom-Lundqvist C, Boriani G, Dan GA, Hills MT, Hylek EM,
3835 LaHaye SA, Lip GY, Lobban T, Mandrola J, McCabe PJ, Pedersen SS, Pisters R, Stewart S, Wood K,
3836 Potpara TS, Gorenek B, Conti JB, Keegan R, Power S, Hendriks J, Ritter P, Calkins H, Violi F,
3837 Hurwitz J. Cardiac tachyarrhythmias and patient values and preferences for their management: the
3838 European Heart Rhythm Association (EHRA) consensus document endorsed by the Heart Rhythm
3839 Society (HRS), Asia Pacific Heart Rhythm Society (APHRS), and Sociedad Latinoamericana de
3840 Estimulacion Cardiaca y Electrofisiologia (SOLEACE). *Europace* 2015;**17**:1747-1769.
- 3841 338. Hendriks JM, de Wit R, Vrijhoef HJ, Tieleman RG, Crijns HJ. An integrated chronic care
3842 program for patients with atrial fibrillation: study protocol and methodology for an ongoing prospective
3843 randomised controlled trial. *Int J Nurs Stud* 2010;**47**:1310-1316.

- 3844 339. Donal E, Lip GY, Galderisi M, Goette A, Shah D, Marwan M, Lederlin M, Mondillo S,
3845 Edvardsen T, Sitges M, Grapsa J, Garbi M, Senior R, Gimelli A, Potpara TS, Van Gelder IC, Gorenek
3846 B, Mabo P, Lancellotti P, Kuck KH, Popescu BA, Hindricks G, Habib G, Cosyns B, Delgado V,
3847 Haugaa KH, Muraru D, Nieman K, Cohen A. EACVI/EHRA Expert Consensus Document on the role
3848 of multi-modality imaging for the evaluation of patients with atrial fibrillation. *Eur Heart J Cardiovasc*
3849 *Imaging* 2016;**17**:355-383.
- 3850 340. Lang RM, Badano LP, Mor-Avi V, Afilalo J, Armstrong A, Ernande L, Flachskampf FA, Foster
3851 E, Goldstein SA, Kuznetsova T, Lancellotti P, Muraru D, Picard MH, Rietzschel ER, Rudski L,
3852 Spencer KT, Tsang W, Voigt JU. Recommendations for cardiac chamber quantification by
3853 echocardiography in adults: an update from the american society of echocardiography and the
3854 European association of cardiovascular imaging. *Eur Heart J Cardiovasc Imaging* 2015;**16**:233-271.
- 3855 341. Filion KB, Agarwal SK, Ballantyne CM, Eberg M, Hoogeveen RC, Huxley RR, Loehr LR,
3856 Nambi V, Soliman EZ, Alonso A. High-sensitivity cardiac troponin T and the risk of incident atrial
3857 fibrillation: The Atherosclerosis Risk in Communities (ARIC) study. *Am Heart J* 2015;**169**:31-38
- 3858 342. Aviles RJ, Martin DO, Apperson-Hansen C, Houghtaling PL, Rautaharju P, Kronmal RA,
3859 Tracy RP, Van Wagener DR, Psaty BM, Lauer MS, Chung MK. Inflammation as a risk factor for atrial
3860 fibrillation. *Circulation* 2003;**108**:3006-3010.
- 3861 343. Patton KK, Ellinor PT, Heckbert SR, Christenson RH, DeFilippi C, Gottdiener JS, Kronmal
3862 RA. N-terminal pro-B-type natriuretic peptide is a major predictor of the development of atrial
3863 fibrillation: the Cardiovascular Health Study. *Circulation* 2009;**120**:1768-1774.
- 3864 344. Bartel T, Erbel R, Acute Trial Investigators. Transoesophageal echocardiography for
3865 immediate and safe cardioversion in patients with atrial fibrillation. *Eur Heart J* 2001;**22**:2041-2044.
- 3866 345. Mahnkopf C, Mitlacher M, Brachmann J. [Relevance of magnetic resonance imaging for
3867 catheter ablation of atrial fibrillation]. *Herzschrittmacherther Elektrophysiol* 2014;**25**:252-257.
- 3868 346. Haemers P, Claus P, Willems R. The use of cardiac magnetic resonance imaging in the
3869 diagnostic workup and treatment of atrial fibrillation. *Cardiol Res Pract* 2012;**2012**:658937.
- 3870 347. Ling LH, Kistler PM, Ellims AH, Iles LM, Lee G, Hughes GL, Kalman JM, Kaye DM, Taylor AJ.
3871 Diffuse ventricular fibrosis in atrial fibrillation: noninvasive evaluation and relationships with aging and
3872 systolic dysfunction. *J Am Coll Cardiol* 2012;**60**:2402-2408.
- 3873 348. Lewalter T, Ibrahim R, Albers B, Camm AJ. An update and current expert opinions on
3874 percutaneous left atrial appendage occlusion for stroke prevention in atrial fibrillation. *Europace*
3875 2013;**15**:652-656.
- 3876 349. Kirchhof P, Auricchio A, Bax J, Crijns H, Camm J, Diener HC, Goette A, Hindricks G,
3877 Hohnloser S, Kappenberger L, Kuck KH, Lip GY, Olsson B, Meinertz T, Priori S, Ravens U, Steinbeck
3878 G, Svernhage E, Tijssen J, Vincent A, Breithardt G. Outcome parameters for trials in atrial fibrillation:
3879 executive summary: Recommendations from a consensus conference organized by the German Atrial
3880 Fibrillation Competence Network (AFNET) and the European Heart Rhythm Association (EHRA). *Eur*
3881 *Heart J* 2007;**28**:2803-2817.
- 3882 350. Alonso-Coello P, Montori VM, Sola I, Schunemann HJ, Devereaux P, Charles C, Roura M,
3883 Diaz MG, Souto JC, Alonso R, Oliver S, Ruiz R, Coll-Vinent B, Diez AI, Gich I, Guyatt G. Values and
3884 preferences in oral anticoagulation in patients with atrial fibrillation, physicians' and patients'
3885 perspectives: protocol for a two-phase study. *BMC Health Serv Res* 2008;**8**:221.
- 3886 351. Lip GY, Al-Khatib SM, Cosio FG, Banerjee A, Savelieva I, Ruskin J, Blendea D, Nattel S, De
3887 Bono J, Conroy JM, Hess PL, Guasch E, Halperin JL, Kirchhof P, MD GC, Camm AJ. Contemporary
3888 management of atrial fibrillation: what can clinical registries tell us about stroke prevention and current
3889 therapeutic approaches? *J Am Heart Assoc* 2014;**3**.
- 3890 352. Gorst-Rasmussen A, Skjoth F, Larsen TB, Rasmussen LH, Lip GY, Lane DA. Dabigatran
3891 adherence in atrial fibrillation patients during the first year after diagnosis: a nationwide cohort study. *J*
3892 *Thromb Haemost* 2015;**13**:495-504.
- 3893 353. Hart RG, Pearce LA, Aguilar MI. Adjusted-dose warfarin versus aspirin for preventing stroke
3894 in patients with atrial fibrillation. *Ann Intern Med* 2007;**147**:590-592.
- 3895 354. Connolly SJ, Eikelboom J, Joyner C, Diener HC, Hart R, Golitsyn S, Flaker G, Avezum A,
3896 Hohnloser SH, Diaz R, Talajic M, Zhu J, Pais P, Budaj A, Parkhomenko A, Jansky P, Commerford P,
3897 Tan RS, Sim KH, Lewis BS, Van Mieghem W, Lip GY, Kim JH, Lanus-Zanetti F, Gonzalez-Hermosillo
3898 A, Dans AL, Munawar M, O'Donnell M, Lawrence J, Lewis G, Afzal R, Yusuf S, AVERROES Steering
3899 Committee Investigators. Apixaban in patients with atrial fibrillation. *N Engl J Med* 2011;**364**:806-817.
- 3900 355. Frankel DS, Parker SE, Rosenfeld LE, Gorelick PB. HRS/NSA 2014 Survey of Atrial
3901 Fibrillation and Stroke: Gaps in Knowledge and Perspective, Opportunities for Improvement. *Heart*
3902 *Rhythm* 2015.

- 3903 356. Le Heuzey JY, Ammentorp B, Darius H, De Caterina R, Schilling RJ, Schmitt J, Zamorano JL,
3904 Kirchhof P. Differences among western European countries in anticoagulation management of atrial
3905 fibrillation. Data from the PREFER IN AF registry. *Thromb Haemost* 2014;**111**:833-841.
- 3906 357. O'Brien EC, Holmes DN, Ansell JE, Allen LA, Hylek E, Kowey PR, Gersh BJ, Fonarow GC,
3907 Koller CR, Ezekowitz MD, Mahaffey KW, Chang P, Peterson ED, Piccini JP, Singer DE. Physician
3908 practices regarding contraindications to oral anticoagulation in atrial fibrillation: findings from the
3909 Outcomes Registry for Better Informed Treatment of Atrial Fibrillation (ORBIT-AF) registry. *Am Heart*
3910 *J* 2014;**167**:601-609 e601.
- 3911 358. Fang MC, Go AS, Chang Y, Borowsky LH, Pomernacki NK, Udaltsova N, Singer DE. Warfarin
3912 discontinuation after starting warfarin for atrial fibrillation. *Circ Cardiovasc Qual Outcomes*
3913 2010;**3**:624-631.
- 3914 359. Zalesak M, Siu K, Francis K, Yu C, Alvrtsyan H, Rao Y, Walker D, Sander S, Miyasato G,
3915 Matchar D, Sanchez H. Higher persistence in newly diagnosed nonvalvular atrial fibrillation patients
3916 treated with dabigatran versus warfarin. *Circ Cardiovasc Qual Outcomes* 2013;**6**:567-574.
- 3917 360. Donze J, Clair C, Hug B, Rodondi N, Waeber G, Cornuz J, Aujesky D. Risk of falls and major
3918 bleeds in patients on oral anticoagulation therapy. *Am J Med* 2012;**125**:773-778.
- 3919 361. Man-Son-Hing M, Nichol G, Lau A, Laupacis A. Choosing antithrombotic therapy for elderly
3920 patients with atrial fibrillation who are at risk for falls. *Arch Intern Med* 1999;**159**:677-685.
- 3921 362. Mant J, Hobbs FD, Fletcher K, Roalfe A, Fitzmaurice D, Lip GY, Murray E, BAFTA
3922 investigators, Midland Research Practices Network (MidReC). Warfarin versus aspirin for stroke
3923 prevention in an elderly community population with atrial fibrillation (the Birmingham Atrial Fibrillation
3924 Treatment of the Aged Study, BAFTA): a randomised controlled trial. *Lancet* 2007;**370**:493-503.
- 3925 363. Diener HC, Eikelboom J, Connolly SJ, Joyner CD, Hart RG, Lip GY, O'Donnell M, Hohnloser
3926 SH, Hankey GJ, Shestakovska O, Yusuf S, AVERROES Steering Committee and Investigators.
3927 Apixaban versus aspirin in patients with atrial fibrillation and previous stroke or transient ischaemic
3928 attack: a predefined subgroup analysis from AVERROES, a randomised trial. *Lancet Neurol*
3929 2012;**11**:225-231.
- 3930 364. The SPAF III Writing Committee for the Stroke Prevention in Atrial Fibrillation Investigators.
3931 Patients with nonvalvular atrial fibrillation at low risk of stroke during treatment with aspirin: Stroke
3932 Prevention in Atrial Fibrillation III Study. *JAMA* 1998;**279**:1273-1277.
- 3933 365. Gage BF, Waterman AD, Shannon W, Boechler M, Rich MW, Radford MJ. Validation of
3934 clinical classification schemes for predicting stroke: results from the National Registry of Atrial
3935 Fibrillation. *JAMA* 2001;**285**:2864-2870.
- 3936 366. van Walraven C, Hart RG, Wells GA, Petersen P, Koudstaal PJ, Gullov AL, Hellemons BS,
3937 Koefed BG, Laupacis A. A clinical prediction rule to identify patients with atrial fibrillation and a low
3938 risk for stroke while taking aspirin. *Arch Intern Med* 2003;**163**:936-943.
- 3939 367. Wang TJ, Massaro JM, Levy D, Vasani RS, Wolf PA, D'Agostino RB, Larson MG, Kannel WB,
3940 Benjamin EJ. A risk score for predicting stroke or death in individuals with new-onset atrial fibrillation
3941 in the community: the Framingham Heart Study. *JAMA* 2003;**290**:1049-1056.
- 3942 368. Lip GY, Nieuwlaat R, Pisters R, Lane DA, Crijns HJ. Refining clinical risk stratification for
3943 predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach:
3944 the euro heart survey on atrial fibrillation. *Chest* 2010;**137**:263-272.
- 3945 369. Camm AJ, Kirchhof P, Lip GY, Schotten U, Savelieva I, Ernst S, Van Gelder IC, Al-Attar N,
3946 Hindricks G, Prendergast B, Heidbuchel H, Alfieri O, Angelini A, Atar D, Colonna P, De Caterina R,
3947 De Sutter J, Goette A, Gorenek B, Heldal M, Hohloser SH, Kolh P, Le Heuzey JY, Ponikowski P,
3948 Rutten FH, ESC Committee for Practice Guidelines, European Heart Rhythm Association, European
3949 Association for Cardio-Thoracic Surgery. Guidelines for the management of atrial fibrillation: the Task
3950 Force for the Management of Atrial Fibrillation of the European Society of Cardiology (ESC).
3951 *Europace* 2010;**12**:1360-1420.
- 3952 370. Kirchhof P, Curtis AB, Skanes AC, Gillis AM, Samuel Wann L, Camm AJ. Atrial fibrillation
3953 guidelines across the Atlantic: a comparison of the current recommendations of the European Society
3954 of Cardiology/European Heart Rhythm Association/European Association of Cardiothoracic Surgeons,
3955 the American College of Cardiology Foundation/American Heart Association/Heart Rhythm Society,
3956 and the Canadian Cardiovascular Society. *Eur Heart J* 2013;**34**:1471-1474.
- 3957 371. Olesen JB, Lip GY, Hansen ML, Hansen PR, Tolstrup JS, Lindhardsen J, Selmer C, Ahlehoff
3958 O, Olsen AM, Gislason GH, Torp-Pedersen C. Validation of risk stratification schemes for predicting
3959 stroke and thromboembolism in patients with atrial fibrillation: nationwide cohort study. *BMJ*
3960 2011;**342**:d124.

- 3961 372. Chao TF, Liu CJ, Wang KL, Lin YJ, Chang SL, Lo LW, Hu YF, Tuan TC, Chen TJ, Lip GY,
3962 Chen SA. Should atrial fibrillation patients with 1 additional risk factor of the CHA2DS2-VASc score
3963 (beyond sex) receive oral anticoagulation? *J Am Coll Cardiol* 2015;**65**:635-642.
- 3964 373. Lip GY, Skjoth F, Rasmussen LH, Larsen TB. Oral anticoagulation, aspirin, or no therapy in
3965 patients with nonvalvular AF with 0 or 1 stroke risk factor based on the CHA2DS2-VASc score. *J Am*
3966 *Coll Cardiol* 2015;**65**:1385-1394.
- 3967 374. Fauchier L, Lecoq C, Clementy N, Bernard A, Angoulvant D, Ivanes F, Babuty D, Lip GY. Oral
3968 Anticoagulation and the Risk of Stroke or Death in Patients With Atrial Fibrillation and One Additional
3969 Stroke Risk Factor: The Loire Valley Atrial Fibrillation Project. *Chest* 2016;**149**:960-968.
- 3970 375. Joundi RA, Cipriano LE, Sposato LA, Saposnik G, Stroke Outcomes Research Working
3971 Group. Ischemic Stroke Risk in Patients With Atrial Fibrillation and CHA2DS2-VASc Score of 1:
3972 Systematic Review and Meta-Analysis. *Stroke* 2016;**47**:1364-1367.
- 3973 376. Friberg L, Skeppholm M, Terent A. Benefit of anticoagulation unlikely in patients with atrial
3974 fibrillation and a CHA2DS2-VASc score of 1. *J Am Coll Cardiol* 2015;**65**:225-232.
- 3975 377. Lip GY, Skjoth F, Nielsen PB, Larsen TB. Non-valvular atrial fibrillation patients with none or
3976 one additional risk factor of the CHA2DS2-VASc score. A comprehensive net clinical benefit analysis
3977 for warfarin, aspirin, or no therapy. *Thromb Haemost* 2015;**114**:826-834.
- 3978 378. Mikkelsen AP, Lindhardsen J, Lip GY, Gislason GH, Torp-Pedersen C, Olesen JB. Female
3979 sex as a risk factor for stroke in atrial fibrillation: a nationwide cohort study. *J Thromb Haemost*
3980 2012;**10**:1745-1751.
- 3981 379. Wagstaff AJ, Overvad TF, Lip GY, Lane DA. Is female sex a risk factor for stroke and
3982 thromboembolism in patients with atrial fibrillation? A systematic review and meta-analysis. *Qjm*
3983 2014;**107**:955-967.
- 3984 380. Hijazi Z, Oldgren J, Andersson U, Connolly SJ, Ezekowitz MD, Hohnloser SH, Reilly PA,
3985 Vinereanu D, Siegbahn A, Yusuf S, Wallentin L. Cardiac biomarkers are associated with an increased
3986 risk of stroke and death in patients with atrial fibrillation: a Randomized Evaluation of Long-term
3987 Anticoagulation Therapy (RE-LY) substudy. *Circulation* 2012;**125**:1605-1616.
- 3988 381. Hijazi Z, Wallentin L, Siegbahn A, Andersson U, Christersson C, Ezekowitz J, Gersh BJ,
3989 Hanna M, Hohnloser S, Horowitz J, Huber K, Hylek EM, Lopes RD, McMurray JJ, Granger CB. N-
3990 terminal pro-B-type natriuretic peptide for risk assessment in patients with atrial fibrillation: insights
3991 from the ARISTOTLE Trial (Apixaban for the Prevention of Stroke in Subjects With Atrial Fibrillation).
3992 *J Am Coll Cardiol* 2013;**61**:2274-2284.
- 3993 382. Hijazi Z, Lindback J, Alexander JH, Hanna M, Held C, Hylek EM, Lopes RD, Oldgren J,
3994 Siegbahn A, Stewart RA, White HD, Granger CB, Wallentin L, ARISTOTLE and STABILITY
3995 Investigators. The ABC (age, biomarkers, clinical history) stroke risk score: a biomarker-based risk
3996 score for predicting stroke in atrial fibrillation. *Eur Heart J* 2016:[Epub ahead of print].
- 3997 383. Gage BF, Yan Y, Milligan PE, Waterman AD, Culverhouse R, Rich MW, Radford MJ. Clinical
3998 classification schemes for predicting hemorrhage: results from the National Registry of Atrial
3999 Fibrillation (NRAF). *Am Heart J* 2006;**151**:713-719.
- 4000 384. Pisters R, Lane DA, Nieuwlaet R, de Vos CB, Crijns HJ, Lip GY. A novel user-friendly score
4001 (HAS-BLED) to assess 1-year risk of major bleeding in patients with atrial fibrillation: the Euro Heart
4002 Survey. *Chest* 2010;**138**:1093-1100.
- 4003 385. Fang MC, Go AS, Chang Y, Borowsky LH, Pomernacki NK, Udaltsova N, Singer DE. A new
4004 risk scheme to predict warfarin-associated hemorrhage: The ATRIA (Anticoagulation and Risk Factors
4005 in Atrial Fibrillation) Study. *J Am Coll Cardiol* 2011;**58**:395-401.
- 4006 386. Friberg L, Rosenqvist M, Lip GY. Evaluation of risk stratification schemes for ischaemic stroke
4007 and bleeding in 182 678 patients with atrial fibrillation: the Swedish Atrial Fibrillation cohort study. *Eur*
4008 *Heart J* 2012;**33**:1500-1510.
- 4009 387. Hijazi Z, Oldgren J, Lindback J, Alexander JH, Connolly SJ, Eikelboom JW, Ezekowitz MD,
4010 Held C, Hylek EM, Lopes RD, Siegbahn A, Yusuf S, Granger CB, Wallentin L, ARISTOTLE and RE-
4011 LY Investigators. The novel biomarker-based ABC (age, biomarkers, clinical history)-bleeding risk
4012 score for patients with atrial fibrillation: a derivation and validation study. *Lancet* 2016:[Epub ahead of
4013 print].
- 4014 388. O'Brien EC, Simon DN, Thomas LE, Hylek EM, Gersh BJ, Ansell JE, Kowey PR, Mahaffey
4015 KW, Chang P, Fonarow GC, Pencina MJ, Piccini JP, Peterson ED. The ORBIT bleeding score: a
4016 simple bedside score to assess bleeding risk in atrial fibrillation. *Eur Heart J* 2015;**36**:3258-3264.
- 4017 389. Loewen P, Dahri K. Risk of bleeding with oral anticoagulants: an updated systematic review
4018 and performance analysis of clinical prediction rules. *Ann Hematol* 2011;**90**:1191-1200.
- 4019 390. Olesen JB, Lip GY, Hansen PR, Lindhardsen J, Ahlehoff O, Andersson C, Weeke P, Hansen
4020 ML, Gislason GH, Torp-Pedersen C. Bleeding risk in 'real world' patients with atrial fibrillation:

- 4021 comparison of two established bleeding prediction schemes in a nationwide cohort. *J Thromb*
4022 *Haemost* 2011;**9**:1460-1467.
- 4023 391. Van Staa TP, Setakis E, Di Tanna GL, Lane DA, Lip GY. A comparison of risk stratification
4024 schemes for stroke in 79,884 atrial fibrillation patients in general practice. *J Thromb Haemost*
4025 2011;**9**:39-48.
- 4026 392. Roldan V, Marin F, Manzano-Fernandez S, Gallego P, Vilchez JA, Valdes M, Vicente V, Lip
4027 GY. The HAS-BLED score has better prediction accuracy for major bleeding than CHADS2 or
4028 CHA2DS2-VASc scores in anticoagulated patients with atrial fibrillation. *J Am Coll Cardiol*
4029 2013;**62**:2199-2204.
- 4030 393. Wallentin L, Hijazi Z, Andersson U, Alexander JH, De Caterina R, Hanna M, Horowitz JD,
4031 Hylek EM, Lopes RD, Asberg S, Granger CB, Siegbahn A, ARISTOTLE Investigators. Growth
4032 differentiation factor 15, a marker of oxidative stress and inflammation, for risk assessment in patients
4033 with atrial fibrillation: insights from the Apixaban for Reduction in Stroke and Other Thromboembolic
4034 Events in Atrial Fibrillation (ARISTOTLE) trial. *Circulation* 2014;**130**:1847-1858.
- 4035 394. Raunso J, Selmer C, Olesen JB, Charlott MG, Olsen AM, Bretler DM, Nielsen JD, Dominguez
4036 H, Gadsboll N, Kober L, Gislason GH, Torp-Pedersen C, Hansen ML. Increased short-term risk of
4037 thrombo-embolism or death after interruption of warfarin treatment in patients with atrial fibrillation.
4038 *Eur Heart J* 2012;**33**:1886-1892.
- 4039 395. Sjogren V, Grzymala-Lubanski B, Renlund H, Friberg L, Lip GY, Svensson PJ, Sjalander A.
4040 Safety and efficacy of well managed warfarin. A report from the Swedish quality register Auricula.
4041 *Thromb Haemost* 2015;**113**:1370-1377.
- 4042 396. Graham DJ, Reichman ME, Wernecke M, Zhang R, Southworth MR, Levenson M, Sheu TC,
4043 Mott K, Goulding MR, Houstoun M, MaCurdy TE, Worrall C, Kelman JA. Cardiovascular, bleeding,
4044 and mortality risks in elderly medicare patients treated with dabigatran or warfarin for nonvalvular
4045 atrial fibrillation. *Circulation* 2015;**131**:157-164.
- 4046 397. Apostolakis S, Sullivan RM, Olshansky B, Lip GY. Factors affecting quality of anticoagulation
4047 control among patients with atrial fibrillation on warfarin: the SAME-TT(2)R(2) score. *Chest*
4048 2013;**144**:1555-1563.
- 4049 398. Lip GY, Haguenoer K, Saint-Etienne C, Fauchier L. Relationship of the SAME-TT(2)R(2)
4050 score to poor-quality anticoagulation, stroke, clinically relevant bleeding, and mortality in patients with
4051 atrial fibrillation. *Chest* 2014;**146**:719-726.
- 4052 399. Gallego P, Roldan V, Marin F, Galvez J, Valdes M, Vicente V, Lip GY. SAME-TT2R2 score,
4053 time in therapeutic range, and outcomes in anticoagulated patients with atrial fibrillation. *Am J Med*
4054 2014;**127**:1083-1088.
- 4055 400. Eikelboom JW, Connolly SJ, Brueckmann M, Granger CB, Kappetein AP, Mack MJ,
4056 Blatchford J, Devenny K, Friedman J, Guiver K, Harper R, Khder Y, Lobmeyer MT, Maas H, Voigt JU,
4057 Simoons ML, Van de Werf F, RE-ALIGN Investigators. Dabigatran versus warfarin in patients with
4058 mechanical heart valves. *N Engl J Med* 2013;**369**:1206-1214.
- 4059 401. Olesen JB, Sorensen R, Hansen ML, Lamberts M, Weeke P, Mikkelsen AP, Kober L,
4060 Gislason GH, Torp-Pedersen C, Fosbol EL. Non-vitamin K antagonist oral anticoagulation agents in
4061 anticoagulant naive atrial fibrillation patients: Danish nationwide descriptive data 2011-2013.
4062 *Europace* 2015;**17**:187-193.
- 4063 402. Hylek EM, Held C, Alexander JH, Lopes RD, De Caterina R, Wojdyla DM, Huber K, Jansky P,
4064 Steg PG, Hanna M, Thomas L, Wallentin L, Granger CB. Major bleeding in patients with atrial
4065 fibrillation receiving apixaban or warfarin: The ARISTOTLE Trial (Apixaban for Reduction in Stroke
4066 and Other Thromboembolic Events in Atrial Fibrillation): Predictors, Characteristics, and Clinical
4067 Outcomes. *J Am Coll Cardiol* 2014;**63**:2141-2147.
- 4068 403. Flaker GC, Eikelboom JW, Shestakovska O, Connolly SJ, Kaatz S, Budaj A, Husted S, Yusuf
4069 S, Lip GY, Hart RG. Bleeding during treatment with aspirin versus apixaban in patients with atrial
4070 fibrillation unsuitable for warfarin: the apixaban versus acetylsalicylic acid to prevent stroke in atrial
4071 fibrillation patients who have failed or are unsuitable for vitamin K antagonist treatment (AVERROES)
4072 trial. *Stroke* 2012;**43**:3291-3297.
- 4073 404. Connolly SJ, Ezekowitz MD, Yusuf S, Reilly PA, Wallentin L, Randomized Evaluation of Long-
4074 Term Anticoagulation Therapy Investigators. Newly identified events in the RE-LY trial. *N Engl J Med*
4075 2010;**363**:1875-1876.
- 4076 405. Ruff CT, Giugliano RP, Braunwald E, Morrow DA, Murphy SA, Kuder JF, Deenadayalu N,
4077 Jarolim P, Betcher J, Shi M, Brown K, Patel I, Mercuri M, Antman EM. Association between edoxaban
4078 dose, concentration, anti-Factor Xa activity, and outcomes: an analysis of data from the randomised,
4079 double-blind ENGAGE AF-TIMI 48 trial. *Lancet* 2015;**385**:2288-2295.

- 4080 406. Beyer-Westendorf J, Forster K, Pannach S, Ebertz F, Gelbricht V, Thieme C, Michalski F,
4081 Kohler C, Werth S, Sahin K, Tittl L, Hansel U, Weiss N. Rates, management, and outcome of
4082 rivaroxaban bleeding in daily care: results from the Dresden NOAC registry. *Blood* 2014;**124**:955-962.
- 4083 407. Camm AJ, Amarenco P, Haas S, Hess S, Kirchhof P, Kuhls S, van Eickels M, Turpie AG,
4084 XANTUS Investigators. XANTUS: a real-world, prospective, observational study of patients treated
4085 with rivaroxaban for stroke prevention in atrial fibrillation. *Eur Heart J* 2016;**37**:1145-1153.
- 4086 408. Wallentin L, Yusuf S, Ezekowitz MD, Alings M, Flather M, Franzosi MG, Pais P, Dans A,
4087 Eikelboom J, Oldgren J, Pogue J, Reilly PA, Yang S, Connolly SJ, RE-LY investigators. Efficacy and
4088 safety of dabigatran compared with warfarin at different levels of international normalised ratio control
4089 for stroke prevention in atrial fibrillation: an analysis of the RE-LY trial. *Lancet* 2010;**376**:975-983.
- 4090 409. Piccini JP, Hellkamp AS, Lokhnygina Y, Patel MR, Harrell FE, Singer DE, Becker RC,
4091 Breithardt G, Halperin JL, Hankey GJ, Berkowitz SD, Nessel CC, Mahaffey KW, Fox KA, Califf RM,
4092 ROCKET AF Investigators. Relationship between time in therapeutic range and comparative
4093 treatment effect of rivaroxaban and warfarin: results from the ROCKET AF trial. *J Am Heart Assoc*
4094 2014;**3**:e000521.
- 4095 410. Olesen JB, Lip GY, Kamper AL, Hommel K, Kober L, Lane DA, Lindhardsen J, Gislason GH,
4096 Torp-Pedersen C. Stroke and bleeding in atrial fibrillation with chronic kidney disease. *N Engl J Med*
4097 2012;**367**:625-635.
- 4098 411. Albertsen IE, Rasmussen LH, Overvad TF, Graungaard T, Larsen TB, Lip GY. Risk of stroke
4099 or systemic embolism in atrial fibrillation patients treated with warfarin: A systematic review and meta-
4100 analysis. *Stroke* 2013;**44**:1329-1336.
- 4101 412. Hart RG, Pearce LA, Asinger RW, Herzog CA. Warfarin in atrial fibrillation patients with
4102 moderate chronic kidney disease. *Clin J Am Soc Nephrol* 2011;**6**:2599-2604.
- 4103 413. Friberg L, Benson L, Lip GY. Balancing stroke and bleeding risks in patients with atrial
4104 fibrillation and renal failure: the Swedish Atrial Fibrillation Cohort study. *Eur Heart J* 2014.
- 4105 414. Jun M, James MT, Manns BJ, Quinn RR, Ravani P, Tonelli M, Perkovic V, Winkelmayr WC,
4106 Ma Z, Hemmelgarn BR. The association between kidney function and major bleeding in older adults
4107 with atrial fibrillation starting warfarin treatment: population based observational study. *BMJ*
4108 2015;**350**:h246.
- 4109 415. Del-Carpio Munoz F, Gharacholou SM, Munger TM, Friedman PA, Asirvatham SJ, Packer
4110 DL, Noseworthy PA. Meta-Analysis of Renal Function on the Safety and Efficacy of Novel Oral
4111 Anticoagulants for Atrial Fibrillation. *Am J Cardiol* 2016;**117**:69-75.
- 4112 416. Heidbuchel H, Verhamme P, Alings M, Antz M, Diener HC, Hacke W, Oldgren J, Sinnaeve P,
4113 Camm AJ, Kirchhof P. Updated European Heart Rhythm Association Practical Guide on the use of
4114 non-vitamin K antagonist anticoagulants in patients with non-valvular atrial fibrillation. *Europace*
4115 2015;**17**:1467-1507.
- 4116 417. Zimmerman D, Sood MM, Rigatto C, Holden RM, Hiremath S, Clase CM. Systematic review
4117 and meta-analysis of incidence, prevalence and outcomes of atrial fibrillation in patients on dialysis.
4118 *Nephrol Dial Transplant* 2012;**27**:3816-3822.
- 4119 418. Marinigh R, Lane DA, Lip GY. Severe renal impairment and stroke prevention in atrial
4120 fibrillation: implications for thromboprophylaxis and bleeding risk. *J Am Coll Cardiol* 2011;**57**:1339-
4121 1348.
- 4122 419. Wizemann V, Tong L, Satayathum S, Disney A, Akiba T, Fissell RB, Kerr PG, Young EW,
4123 Robinson BM. Atrial fibrillation in hemodialysis patients: clinical features and associations with
4124 anticoagulant therapy. *Kidney Int* 2010;**77**:1098-1106.
- 4125 420. Chan KE, Lazarus JM, Thadhani R, Hakim RM. Warfarin use associates with increased risk
4126 for stroke in hemodialysis patients with atrial fibrillation. *J Am Soc Nephrol* 2009;**20**:2223-2233.
- 4127 421. Winkelmayr WC, Liu J, Setoguchi S, Choudhry NK. Effectiveness and safety of warfarin
4128 initiation in older hemodialysis patients with incident atrial fibrillation. *Clin J Am Soc Nephrol*
4129 2011;**6**:2662-2668.
- 4130 422. Shah M, Avgil Tsadok M, Jackevicius CA, Essebag V, Eisenberg MJ, Rahme E, Humphries
4131 KH, Tu JV, Behloul H, Guo H, Pilote L. Warfarin use and the risk for stroke and bleeding in patients
4132 with atrial fibrillation undergoing dialysis. *Circulation* 2014;**129**:1196-1203.
- 4133 423. Bonde AN, Lip GY, Kamper AL, Hansen PR, Lamberts M, Hommel K, Hansen ML, Gislason
4134 GH, Torp-Pedersen C, Olesen JB. Net clinical benefit of antithrombotic therapy in patients with atrial
4135 fibrillation and chronic kidney disease: a nationwide observational cohort study. *J Am Coll Cardiol*
4136 2014;**64**:2471-2482.
- 4137 424. Chan KE, Edelman ER, Wenger JB, Thadhani RI, Maddux FW. Dabigatran and rivaroxaban
4138 use in atrial fibrillation patients on hemodialysis. *Circulation* 2015;**131**:972-979.

- 4139 425. Hijazi Z, Hohnloser SH, Oldgren J, Andersson U, Connolly SJ, Eikelboom JW, Ezekowitz MD,
4140 Reilly PA, Siegbahn A, Yusuf S, Wallentin L. Efficacy and safety of dabigatran compared with warfarin
4141 in relation to baseline renal function in patients with atrial fibrillation: a RE-LY (Randomized Evaluation
4142 of Long-term Anticoagulation Therapy) trial analysis. *Circulation* 2014;**129**:961-970.
- 4143 426. Fox KA, Piccini JP, Wojdyla D, Becker RC, Halperin JL, Nessel CC, Paolini JF, Hankey GJ,
4144 Mahaffey KW, Patel MR, Singer DE, Califf RM. Prevention of stroke and systemic embolism with
4145 rivaroxaban compared with warfarin in patients with non-valvular atrial fibrillation and moderate renal
4146 impairment. *Eur Heart J* 2011;**32**:2387-2394.
- 4147 427. Hohnloser SH, Hijazi Z, Thomas L, Alexander JH, Amerena J, Hanna M, Keltai M, Lanos F,
4148 Lopes RD, Lopez-Sendon J, Granger CB, Wallentin L. Efficacy of apixaban when compared with
4149 warfarin in relation to renal function in patients with atrial fibrillation: insights from the ARISTOTLE
4150 trial. *Eur Heart J* 2012;**33**:2821-2830.
- 4151 428. Stroke Prevention in Atrial Fibrillation Investigators. Stroke Prevention in Atrial Fibrillation
4152 Study. Final results. *Circulation* 1991;**84**:527-539.
- 4153 429. Olesen JB, Lip GY, Lindhardsen J, Lane DA, Ahlehoff O, Hansen ML, Raunso J, Tolstrup JS,
4154 Hansen PR, Gislason GH, Torp-Pedersen C. Risks of thromboembolism and bleeding with
4155 thromboprophylaxis in patients with atrial fibrillation: A net clinical benefit analysis using a 'real world'
4156 nationwide cohort study. *Thromb Haemost* 2011;**106**:739-749.
- 4157 430. Sjalander S, Sjalander A, Svensson PJ, Friberg L. Atrial fibrillation patients do not benefit
4158 from acetylsalicylic acid. *Europace* 2014;**16**:631-638.
- 4159 431. ACTIVE Writing Group of the ACTIVE Investigators, Connolly S, Pogue J, Hart R, Pfeffer M,
4160 Hohnloser S, Chrolavicius S, Pfeffer M, Hohnloser S, Yusuf S. Clopidogrel plus aspirin versus oral
4161 anticoagulation for atrial fibrillation in the Atrial fibrillation Clopidogrel Trial with Irbesartan for
4162 prevention of Vascular Events (ACTIVE W): a randomised controlled trial. *Lancet* 2006;**367**:1903-
4163 1912.
- 4164 432. Connolly SJ, Pogue J, Eikelboom J, Flaker G, Commerford P, Franzosi MG, Healey JS, Yusuf
4165 S, ACTIVE W Investigators. Benefit of oral anticoagulant over antiplatelet therapy in atrial fibrillation
4166 depends on the quality of international normalized ratio control achieved by centers and countries as
4167 measured by time in therapeutic range. *Circulation* 2008;**118**:2029-2037.
- 4168 433. Connolly SJ, Pogue J, Hart RG, Hohnloser SH, Pfeffer M, Chrolavicius S, Yusuf S, ACTIVE
4169 Investigators. Effect of clopidogrel added to aspirin in patients with atrial fibrillation. *N Engl J Med*
4170 2009;**360**:2066-2078.
- 4171 434. van Walraven C, Hart RG, Connolly S, Austin PC, Mant J, Hobbs FD, Koudstaal PJ, Petersen
4172 P, Perez-Gomez F, Knottnerus JA, Boode B, Ezekowitz MD, Singer DE. Effect of age on stroke
4173 prevention therapy in patients with atrial fibrillation: the atrial fibrillation investigators. *Stroke*
4174 2009;**40**:1410-1416.
- 4175 435. Olesen KH. The natural history of 271 patients with mitral stenosis under medical treatment.
4176 *Br Heart J* 1962;**24**:349-357.
- 4177 436. Perez-Gomez F, Alegria E, Berjon J, Iriarte JA, Zumalde J, Salvador A, Mataix L, NASPEAF
4178 Investigators. Comparative effects of antiplatelet, anticoagulant, or combined therapy in patients with
4179 valvular and nonvalvular atrial fibrillation: a randomized multicenter study. *J Am Coll Cardiol*
4180 2004;**44**:1557-1566.
- 4181 437. Rowe JC, Bland EF, Sprague HB, White PD. The course of mitral stenosis without surgery:
4182 ten- and twenty-year perspectives. *Ann Intern Med* 1960;**52**:741-749.
- 4183 438. Wilson JK, Greenwood WF. The natural history of mitral stenosis. *Can Med Assoc J*
4184 1954;**71**:323-331.
- 4185 439. Cannegieter SC, van der Meer FJ, Briet E, Rosendaal FR. Warfarin and aspirin after heart-
4186 valve replacement. *N Engl J Med* 1994;**330**:507-508; author reply 508-509.
- 4187 440. Chiang CW, Lo SK, Ko YS, Cheng NJ, Lin PJ, Chang CH. Predictors of systemic embolism in
4188 patients with mitral stenosis. A prospective study. *Ann Intern Med* 1998;**128**:885-889.
- 4189 441. Wan Y, Heneghan C, Perera R, Roberts N, Hollowell J, Glasziou P, Bankhead C, Xu Y.
4190 Anticoagulation control and prediction of adverse events in patients with atrial fibrillation: a systematic
4191 review. *Circ Cardiovasc Qual Outcomes* 2008;**1**:84-91.
- 4192 442. Morgan CL, McEwan P, Tukiendorf A, Robinson PA, Clemens A, Plumb JM. Warfarin
4193 treatment in patients with atrial fibrillation: observing outcomes associated with varying levels of INR
4194 control. *Thromb Res* 2009;**124**:37-41.
- 4195 443. Gallagher AM, Setakis E, Plumb JM, Clemens A, van Staa TP. Risks of stroke and mortality
4196 associated with suboptimal anticoagulation in atrial fibrillation patients. *Thromb Haemost*
4197 2011;**106**:968-977.

- 4198 444. De Caterina R, Husted S, Wallentin L, Andreotti F, Arnesen H, Bachmann F, Baigent C,
4199 Huber K, Jespersen J, Kristensen SD, Lip GY, Morais J, Rasmussen LH, Siegbahn A, Verheugt FW,
4200 Weitz JI. Vitamin K antagonists in heart disease: current status and perspectives (Section III). Position
4201 paper of the ESC Working Group on Thrombosis--Task Force on Anticoagulants in Heart Disease.
4202 *Thromb Haemost* 2013;**110**:1087-1107.
- 4203 445. Dans AL, Connolly SJ, Wallentin L, Yang S, Nakamya J, Brueckmann M, Ezekowitz M,
4204 Oldgren J, Eikelboom JW, Reilly PA, Yusuf S. Concomitant use of antiplatelet therapy with dabigatran
4205 or warfarin in the Randomized Evaluation of Long-Term Anticoagulation Therapy (RE-LY) trial.
4206 *Circulation* 2013;**127**:634-640.
- 4207 446. Bajaj NS, Parashar A, Agarwal S, Sodhi N, Poddar KL, Garg A, Tuzcu EM, Kapadia SR.
4208 Percutaneous left atrial appendage occlusion for stroke prophylaxis in nonvalvular atrial fibrillation: a
4209 systematic review and analysis of observational studies. *JACC Cardiovasc Interv* 2014;**7**:296-304.
- 4210 447. Lewalter T, Kanagaratnam P, Schmidt B, Rosenqvist M, Nielsen-Kudsk JE, Ibrahim R, Albers
4211 BA, Camm AJ. Ischaemic stroke prevention in patients with atrial fibrillation and high bleeding risk:
4212 opportunities and challenges for percutaneous left atrial appendage occlusion. *Europace*
4213 2014;**16**:626-630.
- 4214 448. Meier B, Blaauw Y, Khattab AA, Lewalter T, Sievert H, Tondo C, Glikson M. EHRA/EAPCI
4215 expert consensus statement on catheter-based left atrial appendage occlusion. *Europace*
4216 2014;**16**:1397-1416.
- 4217 449. Holmes DR, Jr., Kar S, Price MJ, Whisenant B, Sievert H, Doshi SK, Huber K, Reddy VY.
4218 Prospective randomized evaluation of the Watchman Left Atrial Appendage Closure device in patients
4219 with atrial fibrillation versus long-term warfarin therapy: the PREVAIL trial. *J Am Coll Cardiol*
4220 2014;**64**:1-12.
- 4221 450. Holmes DR, Reddy VY, Turi ZG, Doshi SK, Sievert H, Buchbinder M, Mullin CM, Sick P.
4222 Percutaneous closure of the left atrial appendage versus warfarin therapy for prevention of stroke in
4223 patients with atrial fibrillation: a randomised non-inferiority trial. *Lancet* 2009;**374**:534-542.
- 4224 451. Reddy VY, Doshi SK, Sievert H, Buchbinder M, Neuzil P, Huber K, Halperin JL, Holmes D.
4225 Percutaneous left atrial appendage closure for stroke prophylaxis in patients with atrial fibrillation: 2.3-
4226 Year Follow-up of the PROTECT AF (Watchman Left Atrial Appendage System for Embolic Protection
4227 in Patients with Atrial Fibrillation) Trial. *Circulation* 2013;**127**:720-729.
- 4228 452. Reddy VY, Sievert H, Halperin J, Doshi SK, Buchbinder M, Neuzil P, Huber K, Whisenant B,
4229 Kar S, Swarup V, Gordon N, Holmes D, PROTECT AF Steering Committee and Investigators.
4230 Percutaneous left atrial appendage closure vs warfarin for atrial fibrillation: a randomized clinical trial.
4231 *JAMA* 2014;**312**:1988-1998.
- 4232 453. Holmes DR, Jr., Doshi SK, Kar S, Price MJ, Sanchez JM, Sievert H, Valderrabano M, Reddy
4233 VY. Left Atrial Appendage Closure as an Alternative to Warfarin for Stroke Prevention in Atrial
4234 Fibrillation: A Patient-Level Meta-Analysis. *J Am Coll Cardiol* 2015;**65**:2614-2623.
- 4235 454. Reddy VY, Mobius-Winkler S, Miller MA, Neuzil P, Schuler G, Wiebe J, Sick P, Sievert H. Left
4236 atrial appendage closure with the Watchman device in patients with a contraindication for oral
4237 anticoagulation: the ASAP study (ASA Plavix Feasibility Study With Watchman Left Atrial Appendage
4238 Closure Technology). *J Am Coll Cardiol* 2013;**61**:2551-2556.
- 4239 455. Santoro G, Meucci F, Stolcova M, Rezzaghi M, Mori F, Palmieri C, Paradossi U, Pastormerlo
4240 LE, Rosso G, Berti S. Percutaneous left atrial appendage occlusion in patients with non-valvular atrial
4241 fibrillation: implantation and up to four years follow-up of the AMPLATZER Cardiac Plug.
4242 *EuroIntervention* 2014.
- 4243 456. Badheka AO, Chothani A, Mehta K, Patel NJ, Deshmukh A, Hoosien M, Shah N, Singh V,
4244 Grover P, Savani GT, Panaich SS, Rathod A, Patel N, Arora S, Bhalara V, Coffey JO, O'Neill W,
4245 Makkar R, Grines CL, Schreiber T, Di Biase L, Natale A, Viles-Gonzalez JF. Utilization and adverse
4246 outcomes of percutaneous left atrial appendage closure for stroke prevention in atrial fibrillation in the
4247 United States: influence of hospital volume. *Circ Arrhythm Electrophysiol* 2015;**8**:42-48.
- 4248 457. Pison L, Potpara TS, Chen J, Larsen TB, Bongiorni MG, Blomstrom-Lundqvist C. Left atrial
4249 appendage closure-indications, techniques, and outcomes: results of the European Heart Rhythm
4250 Association Survey. *Europace* 2015;**17**:642-646.
- 4251 458. Price MJ, Gibson DN, Yakubov SJ, Schultz JC, Di Biase L, Natale A, Burkhardt JD, Pershad
4252 A, Byrne TJ, Gidney B, Aragon JR, Goldstein J, Moulton K, Patel T, Knight B, Lin AC, Valderrabano
4253 M. Early safety and efficacy of percutaneous left atrial appendage suture ligation: results from the
4254 U.S. transcatheter LAA ligation consortium. *J Am Coll Cardiol* 2014;**64**:565-572.
- 4255 459. Boersma LV, Schmidt B, Betts TR, Sievert H, Tamburino C, Teiger E, Pokushalov E, Kische
4256 S, Schmitz T, Stein KM, Bergmann MW, EWOLUTION investigators. Implant success and safety of

- 4257 left atrial appendage closure with the WATCHMAN device: peri-procedural outcomes from the
4258 EWOLUTION registry. *Eur Heart J* 2016:[Epub ahead of print].
- 4259 460. Kuramatsu JB, Gerner ST, Schellinger PD, Glahn J, Endres M, Sobesky J, Flechsenhar J,
4260 Neugebauer H, Juttler E, Grau A, Palm F, Rother J, Michels P, Hamann GF, Huwel J, Hagemann G,
4261 Barber B, Terborg C, Trostorf F, Bazner H, Roth A, Wohrle J, Keller M, Schwarz M, Reimann G,
4262 Volkmann J, Mullges W, Kraft P, Classen J, Hobohm C, Horn M, Milewski A, Reichmann H, Schneider
4263 H, Schimmel E, Fink GR, Dohmen C, Stetefeld H, Witte O, Gunther A, Neumann-Haefelin T, Racs
4264 AE, Nueckel M, Erbguth F, Kloska SP, Dorfler A, Kohrmann M, Schwab S, Huttner HB. Anticoagulant
4265 reversal, blood pressure levels, and anticoagulant resumption in patients with anticoagulation-related
4266 intracerebral hemorrhage. *JAMA* 2015;**313**:824-836.
- 4267 461. Budera P, Straka Z, Osmancik P, Vanek T, Jelinek S, Hlavicka J, Fojt R, Cervinka P, Hulman
4268 M, Smid M, Maly M, Widimsky P. Comparison of cardiac surgery with left atrial surgical ablation vs.
4269 cardiac surgery without atrial ablation in patients with coronary and/or valvular heart disease plus
4270 atrial fibrillation: final results of the PRAGUE-12 randomized multicentre study. *Eur Heart J*
4271 2012;**33**:2644-2652.
- 4272 462. Healey JS, Crystal E, Lamy A, Teoh K, Semelhago L, Hohnloser SH, Cybulsky I, Abouzahr L,
4273 Sawchuck C, Carroll S, Morillo C, Kleine P, Chu V, Lonn E, Connolly SJ. Left Atrial Appendage
4274 Occlusion Study (LAAOS): results of a randomized controlled pilot study of left atrial appendage
4275 occlusion during coronary bypass surgery in patients at risk for stroke. *Am Heart J* 2005;**150**:288-293.
- 4276 463. Tsai YC, Phan K, Munkholm-Larsen S, Tian DH, La Meir M, Yan TD. Surgical left atrial
4277 appendage occlusion during cardiac surgery for patients with atrial fibrillation: a meta-analysis. *Eur J*
4278 *Cardiothorac Surg* 2015;**47**:847-854.
- 4279 464. Whitlock RP, Vincent J, Blackall MH, Hirsh J, Fremes S, Novick R, Devereaux PJ, Teoh K,
4280 Lamy A, Connolly SJ, Yusuf S, Carrier M, Healey JS. Left Atrial Appendage Occlusion Study II
4281 (LAAOS II). *Can J Cardiol* 2013;**29**:1443-1447.
- 4282 465. Aryana A, Singh SK, Singh SM, Gearoid O'Neill P, Bowers MR, Allen SL, Lewandowski SL,
4283 Vierra EC, d'Avila A. Association between incomplete surgical ligation of left atrial appendage and
4284 stroke and systemic embolization. *Heart Rhythm* 2015;**12**:1431-1437.
- 4285 466. Gillinov AM, Gelijns AC, Parides MK, DeRose JJ, Jr., Moskowitz AJ, Voisine P, Ailawadi G,
4286 Bouchard D, Smith PK, Mack MJ, Acker MA, Mullen JC, Rose EA, Chang HL, Puskas JD, Couderc
4287 JP, Gardner TJ, Varghese R, Horvath KA, Bolling SF, Michler RE, Geller NL, Ascheim DD, Miller MA,
4288 Bagiella E, Moquete EG, Williams P, Taddei-Peters WC, O'Gara PT, Blackstone EH, Argenziano M,
4289 CTSN Investigators. Surgical ablation of atrial fibrillation during mitral-valve surgery. *N Engl J Med*
4290 2015;**372**:1399-1409.
- 4291 467. Whitlock R, Healey J, Vincent J, Brady K, Teoh K, Royse A, Shah P, Guo Y, Alings M,
4292 Folkeringa RJ, Paparella D, Colli A, Meyer SR, Legare JF, Lamontagne F, Reents W, Boning A,
4293 Connolly S. Rationale and design of the Left Atrial Appendage Occlusion Study (LAAOS) III. *Ann*
4294 *Cardiothorac Surg* 2014;**3**:45-54.
- 4295 468. Boersma LV, Castella M, van Boven W, Berruezo A, Yilmaz A, Nadal M, Sandoval E, Calvo
4296 N, Brugada J, Kelder J, Wijffels M, Mont L. Atrial fibrillation catheter ablation versus surgical ablation
4297 treatment (FAST): a 2-center randomized clinical trial. *Circulation* 2012;**125**:23-30.
- 4298 469. Grau AJ, Weimar C, Buggle F, Heinrich A, Goertler M, Neumaier S, Glahn J, Brandt T, Hacke
4299 W, Diener H. Risk factors, outcome, and treatment in subtypes of ischemic stroke: the German stroke
4300 data bank. *Stroke* 2001;**32**:2559-2566.
- 4301 470. Giles MF, Rothwell PM. Risk of stroke early after transient ischaemic attack: a systematic
4302 review and meta-analysis. *Lancet Neurol* 2007;**6**:1063-1072.
- 4303 471. Emberson J, Lees KR, Lyden P, Blackwell L, Albers G, Bluhmki E, Brott T, Cohen G, Davis S,
4304 Donnan G, Grotta J, Howard G, Kaste M, Koga M, von Kummer R, Lansberg M, Lindley RI, Murray G,
4305 Olivot JM, Parsons M, Tilley B, Toni D, Toyoda K, Wahlgren N, Wardlaw J, Whiteley W, Del Zoppo
4306 GJ, Baigent C, Sandercock P, Hacke W, Stroke Thrombolysis Trialists' Collaborative Group. Effect of
4307 treatment delay, age, and stroke severity on the effects of intravenous thrombolysis with alteplase for
4308 acute ischaemic stroke: a meta-analysis of individual patient data from randomised trials. *Lancet*
4309 2014.
- 4310 472. Diener HC, Stanford S, Abdul-Rahim A, Christensen L, Hougaard KD, Bakhai A, Veltkamp R,
4311 Worthmann H. Anti-thrombotic therapy in patients with atrial fibrillation and intracranial hemorrhage.
4312 *Expert Rev Neurother* 2014;**14**:1019-1028.
- 4313 473. Hankey GJ, Norrving B, Hacke W, Steiner T. Management of acute stroke in patients taking
4314 novel oral anticoagulants. *Int J Stroke* 2014;**9**:627-632.
- 4315 474. Xian Y, Liang L, Smith EE, Schwamm LH, Reeves MJ, Olson DM, Hernandez AF, Fonarow
4316 GC, Peterson ED. Risks of intracranial hemorrhage among patients with acute ischemic stroke

- 4317 receiving warfarin and treated with intravenous tissue plasminogen activator. *JAMA* 2012;**307**:2600-
4318 2608.
- 4319 475. Pollack CV, Jr., Reilly PA, Eikelboom J, Glund S, Verhamme P, Bernstein RA, Dubiel R,
4320 Huisman MV, Hylek EM, Kamphuisen PW, Kreuzer J, Levy JH, Sellke FW, Stangier J, Steiner T,
4321 Wang B, Kam CW, Weitz JI. Idarucizumab for Dabigatran Reversal. *N Engl J Med* 2015;**373**:511-520.
- 4322 476. Badhiwala JH, Nassiri F, Alhazzani W, Selim MH, Farrokhyar F, Spears J, Kulkarni AV, Singh
4323 S, Alqahtani A, Rochweg B, Alshahrani M, Murty NK, Alhazzani A, Yarascavitch B, Reddy K, Zaidat
4324 OO, Almenawer SA. Endovascular Thrombectomy for Acute Ischemic Stroke: A Meta-analysis. *Jama*
4325 2015;**314**:1832-1843.
- 4326 477. Paciaroni M, Agnelli G, Micheli S, Caso V. Efficacy and safety of anticoagulant treatment in
4327 acute cardioembolic stroke: a meta-analysis of randomized controlled trials. *Stroke* 2007;**38**:423-430.
- 4328 478. Heidbuchel H, Verhamme P, Alings M, Antz M, Hacke W, Oldgren J, Sinnaeve P, Camm AJ,
4329 Kirchhof P. European Heart Rhythm Association Practical Guide on the use of new oral
4330 anticoagulants in patients with non-valvular atrial fibrillation. *Europace* 2013;**15**:625-651.
- 4331 479. Diener HC, Connolly SJ, Ezekowitz MD, Wallentin L, Reilly PA, Yang S, Xavier D, Di
4332 Pasquale G, Yusuf S. Dabigatran compared with warfarin in patients with atrial fibrillation and
4333 previous transient ischaemic attack or stroke: a subgroup analysis of the RE-LY trial. *Lancet Neurol*
4334 2010;**9**:1157-1163.
- 4335 480. Hankey GJ, Patel MR, Stevens SR, Becker RC, Breithardt G, Carolei A, Diener HC, Donnan
4336 GA, Halperin JL, Mahaffey KW, Mas JL, Massaro A, Norrving B, Nessel CC, Paolini JF, Roine RO,
4337 Singer DE, Wong L, Califf RM, Fox KA, Hacke W, ROCKET AF Steering Committee Investigators.
4338 Rivaroxaban compared with warfarin in patients with atrial fibrillation and previous stroke or transient
4339 ischaemic attack: a subgroup analysis of ROCKET AF. *Lancet Neurol* 2012;**11**:315-322.
- 4340 481. Easton JD, Lopes RD, Bahit MC, Wojdyla DM, Granger CB, Wallentin L, Alings M, Goto S,
4341 Lewis BS, Rosenqvist M, Hanna M, Mohan P, Alexander JH, Diener HC, ARISTOTLE Committees
4342 and Investigators. Apixaban compared with warfarin in patients with atrial fibrillation and previous
4343 stroke or transient ischaemic attack: a subgroup analysis of the ARISTOTLE trial. *Lancet Neurol*
4344 2012;**11**:503-511.
- 4345 482. Ntaios G, Papavasileiou V, Diener HC, Makaritsis K, Michel P. Nonvitamin-K-antagonist oral
4346 anticoagulants in patients with atrial fibrillation and previous stroke or transient ischemic attack: a
4347 systematic review and meta-analysis of randomized controlled trials. *Stroke* 2012;**43**:3298-3304.
- 4348 483. Paciaroni M, Agnelli G. Should oral anticoagulants be restarted after warfarin-associated
4349 cerebral haemorrhage in patients with atrial fibrillation? *Thromb Haemost* 2014;**111**:14-18.
- 4350 484. Nielsen PB, Larsen TB, Skjoth F, Gorst-Rasmussen A, Rasmussen LH, Lip GY. Restarting
4351 Anticoagulant Treatment After Intracranial Hemorrhage in Patients With Atrial Fibrillation and the
4352 Impact on Recurrent Stroke, Mortality, and Bleeding: A Nationwide Cohort Study. *Circulation*
4353 2015;**132**:517-525.
- 4354 485. Weber R, Brenck J, Diener HC. Antiplatelet therapy in cerebrovascular disorders. *Handb Exp*
4355 *Pharmacol* 2012:519-546.
- 4356 486. Flaker GC, Gruber M, Connolly SJ, Goldman S, Chaparro S, Vahanian A, Halinen MO,
4357 Horrow J, Halperin JL. Risks and benefits of combining aspirin with anticoagulant therapy in patients
4358 with atrial fibrillation: an exploratory analysis of stroke prevention using an oral thrombin inhibitor in
4359 atrial fibrillation (SPORTIF) trials. *Am Heart J* 2006;**152**:967-973.
- 4360 487. Yung D, Kapral MK, Asllani E, Fang J, Lee DS, Investigators of the Registry of the Canadian
4361 Stroke Network. Reinitiation of anticoagulation after warfarin-associated intracranial hemorrhage and
4362 mortality risk: the Best Practice for Reinitiating Anticoagulation Therapy After Intracranial Bleeding
4363 (BRAIN) study. *Can J Cardiol* 2012;**28**:33-39.
- 4364 488. Roskell NS, Samuel M, Noack H, Monz BU. Major bleeding in patients with atrial fibrillation
4365 receiving vitamin K antagonists: a systematic review of randomized and observational studies.
4366 *Europace* 2013;**15**:787-797.
- 4367 489. Mancia G, Fagard R, Narkiewicz K, Redon J, Zanchetti A, Bohm M, Christiaens T, Cifkova R,
4368 De Backer G, Dominiczak A, Galderisi M, Grobbee DE, Jaarsma T, Kirchhof P, Kjeldsen SE, Laurent
4369 S, Manolis AJ, Nilsson PM, Ruilope LM, Schmieder RE, Sirnes PA, Sleight P, Viigimaa M, Waeber B,
4370 Zannad F, Redon J, Dominiczak A, Narkiewicz K, Nilsson PM, Burnier M, Viigimaa M, Ambrosioni E,
4371 Caulfield M, Coca A, Olsen MH, Schmieder RE, Tsioufis C, van de Borne P, Zamorano JL, Achenbach
4372 S, Baumgartner H, Bax JJ, Bueno H, Dean V, Deaton C, Erol C, Fagard R, Ferrari R, Hasdai D, Hoes
4373 AW, Kirchhof P, Knuuti J, Kolh P, Lancellotti P, Linhart A, Nihoyannopoulos P, Piepoli MF, Ponikowski
4374 P, Sirnes PA, Tamargo JL, Tendera M, Torbicki A, Wijns W, Windecker S, Clement DL, Coca A,
4375 Gillebert TC, Tendera M, Rosei EA, Ambrosioni E, Anker SD, Bauersachs J, Hitij JB, Caulfield M, De
4376 Buyzere M, De Geest S, Derumeaux GA, Erdine S, Farsang C, Funck-Brentano C, Gerc V, Germano

- 4377 G, Gielen S, Haller H, Hoes AW, Jordan J, Kahan T, Komajda M, Lovic D, Mahrholdt H, Olsen MH,
4378 Ostergren J, Parati G, Perk J, Polonia J, Popescu BA, Reiner Z, Ryden L, Sirenko Y, Stanton A,
4379 Struijker-Boudier H, Tsioufis C, van de Borne P, Vlachopoulos C, Volpe M, Wood DA. 2013 ESH/ESC
4380 guidelines for the management of arterial hypertension: the Task Force for the Management of
4381 Arterial Hypertension of the European Society of Hypertension (ESH) and of the European Society of
4382 Cardiology (ESC). *Eur Heart J* 2013;**34**:2159-2219.
- 4383 490. Eikelboom JW, Wallentin L, Connolly SJ, Ezekowitz M, Healey JS, Oldgren J, Yang S, Alings
4384 M, Kaatz S, Hohnloser SH, Diener HC, Franzosi MG, Huber K, Reilly P, Varrone J, Yusuf S. Risk of
4385 bleeding with 2 doses of dabigatran compared with warfarin in older and younger patients with atrial
4386 fibrillation: an analysis of the randomized evaluation of long-term anticoagulant therapy (RE-LY) trial.
4387 *Circulation* 2011;**123**:2363-2372.
- 4388 491. Goodman SG, Wojdyla DM, Piccini JP, White HD, Paolini JF, Nessel CC, Berkowitz SD,
4389 Mahaffey KW, Patel MR, Sherwood MW, Becker RC, Halperin JL, Hacke W, Singer DE, Hankey GJ,
4390 Breithardt G, Fox KA, Califf RM, ROCKET AF Investigators. Factors associated with major bleeding
4391 events: insights from the ROCKET AF trial (rivaroxaban once-daily oral direct factor Xa inhibition
4392 compared with vitamin K antagonism for prevention of stroke and embolism trial in atrial fibrillation). *J*
4393 *Am Coll Cardiol* 2014;**63**:891-900.
- 4394 492. Chang HY, Zhou M, Tang W, Alexander GC, Singh S. Risk of gastrointestinal bleeding
4395 associated with oral anticoagulants: population based retrospective cohort study. *BMJ*
4396 2015;**350**:h1585.
- 4397 493. Abraham NS, Singh S, Alexander GC, Heien H, Haas LR, Crown W, Shah ND. Comparative
4398 risk of gastrointestinal bleeding with dabigatran, rivaroxaban, and warfarin: population based cohort
4399 study. *Bmj* 2015;**350**:h1857.
- 4400 494. Björck F, Renlund H, Lip GYH, Wester P, Svensson PJ, Själander A. Outcomes in a Warfarin-
4401 Treated Population With Atrial Fibrillation. *JAMA Cardiology* 2016.
- 4402 495. Jacobs LG, Billett HH, Freeman K, Dinglas C, Jumaquio L. Anticoagulation for stroke
4403 prevention in elderly patients with atrial fibrillation, including those with falls and/or early-stage
4404 dementia: a single-center, retrospective, observational study. *Am J Geriatr Pharmacother* 2009;**7**:159-
4405 166.
- 4406 496. Banerjee A, Clementy N, Haguenoer K, Fauchier L, Lip GY. Prior history of falls and risk of
4407 outcomes in atrial fibrillation: the Loire Valley Atrial Fibrillation Project. *Am J Med* 2014;**127**:972-978.
- 4408 497. Palareti G, Cosmi B. Bleeding with anticoagulation therapy - who is at risk, and how best to
4409 identify such patients. *Thromb Haemost* 2009;**102**:268-278.
- 4410 498. van Schie RM, Wadelius MI, Kamali F, Daly AK, Manolopoulos VG, de Boer A, Barallon R,
4411 Verhoef TI, Kirchheiner J, Haschke-Becher E, Briz M, Rosendaal FR, Redekop WK, Pirmohamed M,
4412 Maitland van der Zee AH. Genotype-guided dosing of coumarin derivatives: the European
4413 pharmacogenetics of anticoagulant therapy (EU-PACT) trial design. *Pharmacogenomics*
4414 2009;**10**:1687-1695.
- 4415 499. International Warfarin Pharmacogenetics Consortium, Klein TE, Altman RB, Eriksson N,
4416 Gage BF, Kimmel SE, Lee MT, Limdi NA, Page D, Roden DM, Wagner MJ, Caldwell MD, Johnson
4417 JA. Estimation of the warfarin dose with clinical and pharmacogenetic data. *N Engl J Med*
4418 2009;**360**:753-764.
- 4419 500. Schwarz UI, Ritchie MD, Bradford Y, Li C, Dudek SM, Frye-Anderson A, Kim RB, Roden DM,
4420 Stein CM. Genetic determinants of response to warfarin during initial anticoagulation. *N Engl J Med*
4421 2008;**358**:999-1008.
- 4422 501. Tang T, Liu J, Zuo K, Cheng J, Chen L, Lu C, Han S, Xu J, Jia Z, Ye M, Pei E, Zhang X, Li M.
4423 Genotype-Guided Dosing of Coumarin Anticoagulants: A Meta-analysis of Randomized Controlled
4424 Trials. *J Cardiovasc Pharmacol Ther* 2015;**20**:387-394.
- 4425 502. Douketis JD, Spyropoulos AC, Kaatz S, Becker RC, Caprini JA, Dunn AS, Garcia DA,
4426 Jacobson A, Jaffer AK, Kong DF, Schulman S, Turpie AG, Hasselblad V, Ortel TL, BRIDGE
4427 Investigators. Perioperative Bridging Anticoagulation in Patients with Atrial Fibrillation. *N Engl J Med*
4428 2015;**373**:823-833.
- 4429 503. Cuker A, Siegal DM, Crowther MA, Garcia DA. Laboratory measurement of the anticoagulant
4430 activity of the non-vitamin K oral anticoagulants. *J Am Coll Cardiol* 2014;**64**:1128-1139.
- 4431 504. Niessner A, Tamargo J, Morais J, Koller L, Wassmann S, Husted SE, Torp-Pedersen C,
4432 Kjeldsen K, Lewis BS, Drexel H, Kaski JC, Atar D, Storey RF, Lip GY, Verheugt FW, Agewall S.
4433 Reversal strategies for non-vitamin K antagonist oral anticoagulants: a critical appraisal of available
4434 evidence and recommendations for clinical management-a joint position paper of the European
4435 Society of Cardiology Working Group on Cardiovascular Pharmacotherapy and European Society of
4436 Cardiology Working Group on Thrombosis. *Eur Heart J* 2015:[Epub ahead of print].

- 4437 505. Hanley JP. Warfarin reversal. *J Clin Pathol* 2004;**57**:1132-1139.
- 4438 506. Parry-Jones AR, Di Napoli M, Goldstein JN, Schreuder FH, Tetri S, Tatlisumak T, Yan B, van
4439 Nieuwenhuizen KM, Dequatre-Ponchelle N, Lee-Archer M, Horstmann S, Wilson D, Pomero F,
4440 Masotti L, Lerpiniere C, Godoy DA, Cohen AS, Houben R, Salman RA, Pennati P, Fenoglio L,
4441 Werring D, Veltkamp R, Wood E, Dewey HM, Cordonnier C, Klijn CJ, Meligeni F, Davis SM,
4442 Huhtakangas J, Staals J, Rosand J, Meretoja A. Reversal strategies for vitamin K antagonists in acute
4443 intracerebral hemorrhage. *Ann Neurol* 2015;**78**:54-62.
- 4444 507. Goldstein JN, Refaai MA, Milling TJ, Jr., Lewis B, Goldberg-Alberts R, Hug BA, Sarode R.
4445 Four-factor prothrombin complex concentrate versus plasma for rapid vitamin K antagonist reversal in
4446 patients needing urgent surgical or invasive interventions: a phase 3b, open-label, non-inferiority,
4447 randomised trial. *Lancet* 2015;**385**:2077-2087.
- 4448 508. Siegal DM, Curnutte JT, Connolly SJ, Lu G, Conley PB, Wiens BL, Mathur VS, Castillo J,
4449 Bronson MD, Leeds JM, Mar FA, Gold A, Crowther MA. Andexanet Alfa for the Reversal of Factor Xa
4450 Inhibitor Activity. *N Engl J Med* 2015;**373**:2413-2424.
- 4451 509. Crowther M, Crowther MA. Antidotes for novel oral anticoagulants: current status and future
4452 potential. *Arterioscler Thromb Vasc Biol* 2015;**35**:1736-1745.
- 4453 510. Staerk L, Lip GY, Olesen JB, Fosbol EL, Pallisgaard JL, Bonde AN, Gundlund A, Lindhardt
4454 TB, Hansen ML, Torp-Pedersen C, Gislason GH. Stroke and recurrent haemorrhage associated with
4455 antithrombotic treatment after gastrointestinal bleeding in patients with atrial fibrillation: nationwide
4456 cohort study. *BMJ* 2015;**351**:h5876.
- 4457 511. Felmeden DC, Lip GY. Antithrombotic therapy in hypertension: a Cochrane Systematic
4458 review. *J Hum Hypertens* 2005;**19**:185-196.
- 4459 512. Sharma M, Cornelius VR, Patel JP, Davies JG, Molokhia M. Efficacy and Harms of Direct
4460 Oral Anticoagulants in the Elderly for Stroke Prevention in Atrial Fibrillation and Secondary Prevention
4461 of Venous Thromboembolism: Systematic Review and Meta-Analysis. *Circulation* 2015;**132**:194-204.
- 4462 513. Ruiz-Nodar JM, Marin F, Hurtado JA, Valencia J, Pinar E, Pineda J, Gimeno JR, Sogorb F,
4463 Valdes M, Lip GYH. Anticoagulant and antiplatelet therapy use in 426 patients with atrial fibrillation
4464 undergoing percutaneous coronary intervention and stent implantation implications for bleeding risk
4465 and prognosis. *J Am Coll Cardiol* 2008;**51**:818-825.
- 4466 514. Hansen ML, Sorensen R, Clausen MT, Fog-Petersen ML, Raunso J, Gadsboll N, Gislason
4467 GH, Folke F, Andersen SS, Schramm TK, Abildstrom SZ, Poulsen HE, Kober L, Torp-Pedersen C.
4468 Risk of bleeding with single, dual, or triple therapy with warfarin, aspirin, and clopidogrel in patients
4469 with atrial fibrillation. *Arch Intern Med* 2010;**170**:1433-1441.
- 4470 515. Lamberts M, Olesen JB, Ruwald MH, Hansen CM, Karasoy D, Kristensen SL, Kober L, Torp-
4471 Pedersen C, Gislason GH, Hansen ML. Bleeding after initiation of multiple antithrombotic drugs,
4472 including triple therapy, in atrial fibrillation patients following myocardial infarction and coronary
4473 intervention: a nationwide cohort study. *Circulation* 2012;**126**:1185-1193.
- 4474 516. Windecker S, Kolh P, Alfonso F, Collet JP, Cremer J, Falk V, Filippatos G, Hamm C, Head
4475 SJ, Juni P, Kappetein AP, Kastrati A, Knuuti J, Landmesser U, Laufer G, Neumann FJ, Richter DJ,
4476 Schauerte P, Sousa Uva M, Stefanini GG, Taggart DP, Torracca L, Valgimigli M, Wijns W, Witkowski
4477 A. 2014 ESC/EACTS Guidelines on myocardial revascularization: The Task Force on Myocardial
4478 Revascularization of the European Society of Cardiology (ESC) and the European Association for
4479 Cardio-Thoracic Surgery (EACTS). Developed with the special contribution of the European
4480 Association of Percutaneous Cardiovascular Interventions (EAPCI). *Eur Heart J* 2014;**35**:2541-2619.
- 4481 517. Vandvik PO, Lincoff AM, Gore JM, Gutterman DD, Sonnenberg FA, Alonso-Coello P, Akl EA,
4482 Lansberg MG, Guyatt GH, Spencer FA, American College of Chest Physicians. Primary and
4483 secondary prevention of cardiovascular disease: Antithrombotic Therapy and Prevention of
4484 Thrombosis, 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice
4485 Guidelines. *Chest* 2012;**141**:e637S-668S.
- 4486 518. Rubboli A, Faxon DP, Juhani Airaksinen KE, Schlitt A, Marin F, Bhatt DL, Lip GYH. The
4487 optimal management of patients on oral anticoagulation undergoing coronary artery stenting. The
4488 10th Anniversary Overview. *Thromb Haemost* 2014;**112**:1080-1087.
- 4489 519. Oldgren J, Wallentin L, Alexander JH, James S, Jonelid B, Steg G, Sundstrom J. New oral
4490 anticoagulants in addition to single or dual antiplatelet therapy after an acute coronary syndrome: a
4491 systematic review and meta-analysis. *Eur Heart J* 2013;**34**:1670-1680.
- 4492 520. Lip GY, Windecker S, Huber K, Kirchhof P, Marin F, Ten Berg JM, Haeusler KG, Boriani G,
4493 Capodanno D, Gilard M, Zeymer U, Lane D, Storey RF, Bueno H, Collet JP, Fauchier L, Halvorsen S,
4494 Lettino M, Morais J, Mueller C, Potpara TS, Rasmussen LH, Rubboli A, Tamargo J, Valgimigli M,
4495 Zamorano JL. Management of antithrombotic therapy in atrial fibrillation patients presenting with acute
4496 coronary syndrome and/or undergoing percutaneous coronary or valve interventions: a joint

- 4497 consensus document of the European Society of Cardiology Working Group on Thrombosis,
4498 European Heart Rhythm Association (EHRA), European Association of Percutaneous Cardiovascular
4499 Interventions (EAPCI) and European Association of Acute Cardiac Care (ACCA) endorsed by the
4500 Heart Rhythm Society (HRS) and Asia-Pacific Heart Rhythm Society (APHS). *Eur Heart J*
4501 2014;**35**:3155-3179.
- 4502 521. Mega JL, Braunwald E, Mohanavelu S, Burton P, Poulter R, Misselwitz F, Hricak V,
4503 Barnathan ES, Bordes P, Witkowski A, Markov V, Oppenheimer L, Gibson CM, ATLAS ACS-TIMI 46
4504 study group. Rivaroxaban versus placebo in patients with acute coronary syndromes (ATLAS ACS-
4505 TIMI 46): a randomised, double-blind, phase II trial. *Lancet* 2009;**374**:29-38.
- 4506 522. Sarafoff N, Martischinig A, Wealer J, Mayer K, Mehilli J, Sibbing D, Kastrati A. Triple therapy
4507 with aspirin, prasugrel, and vitamin K antagonists in patients with drug-eluting stent implantation and
4508 an indication for oral anticoagulation. *J Am Coll Cardiol* 2013;**61**:2060-2066.
- 4509 523. Jackson LR, 2nd, Ju C, Zettler M, Messenger JC, Cohen DJ, Stone GW, Baker BA, Efron M,
4510 Peterson ED, Wang TY. Outcomes of Patients With Acute Myocardial Infarction Undergoing
4511 Percutaneous Coronary Intervention Receiving an Oral Anticoagulant and Dual Antiplatelet Therapy:
4512 A Comparison of Clopidogrel Versus Prasugrel From the TRANSLATE-ACS Study. *JACC Cardiovasc*
4513 *Interv* 2015;**8**:1880-1889.
- 4514 524. Dewilde WJM, Oirbans T, Verheugt FWA, Kelder JC, De Smet BJGL, Herrman J-P,
4515 Adriaenssens T, Vrolix M, Heestermans AACM, Vis MM, Tijssen JGP, van 't Hof AW, ten Berg JM. Use
4516 of clopidogrel with or without aspirin in patients taking oral anticoagulant therapy and undergoing
4517 percutaneous coronary intervention: an open-label, randomised, controlled trial. *Lancet*
4518 2013;**381**:1107-1115.
- 4519 525. Braun OÖ, Bico B, Chaudhry U, Wagner H, Koul S, Tyden P, Schersten F, Jovinge S,
4520 Svensson PJ, Gustav Smith J, van der Pals J. Concomitant use of warfarin and ticagrelor as an
4521 alternative to triple antithrombotic therapy after an acute coronary syndrome. *Thromb Res*
4522 2015;**135**:26-30.
- 4523 526. Nikolaidou T, Channer KS. Chronic atrial fibrillation: a systematic review of medical heart rate
4524 control management. *Postgrad Med J* 2009;**85**:303-312.
- 4525 527. Tamariz LJ, Bass EB. Pharmacological rate control of atrial fibrillation. *Cardiol Clin*
4526 2004;**22**:35-45.
- 4527 528. Segal JB, McNamara RL, Miller MR, Kim N, Goodman SN, Powe NR, Robinson K, Yu D,
4528 Bass EB. The evidence regarding the drugs used for ventricular rate control. In. *J Fam Practice*; 2000,
4529 47-59.
- 4530 529. Schreck DM, Rivera AR, Tricarico VJ. Emergency management of atrial fibrillation and flutter:
4531 intravenous diltiazem versus intravenous digoxin. *Ann Emerg Med* 1997;**29**:135-140.
- 4532 530. Siu CW, Lau CP, Lee WL, Lam KF, Tse HF. Intravenous diltiazem is superior to intravenous
4533 amiodarone or digoxin for achieving ventricular rate control in patients with acute uncomplicated atrial
4534 fibrillation. *Crit Care Med* 2009;**37**:2174-2179; quiz 2180.
- 4535 531. Tisdale JE, Padhi ID, Goldberg AD, Silverman NA, Webb CR, Higgins RS, Paone G, Frank
4536 DM, Borzak S. A randomized, double-blind comparison of intravenous diltiazem and digoxin for atrial
4537 fibrillation after coronary artery bypass surgery. *Am Heart J* 1998;**135**:739-747.
- 4538 532. Scheuermeyer FX, Grafstein E, Stenstrom R, Christenson J, Heslop C, Heilbron B, McGrath
4539 L, Innes G. Safety and efficiency of calcium channel blockers versus beta-blockers for rate control in
4540 patients with atrial fibrillation and no acute underlying medical illness. *Acad Emerg Med* 2013;**20**:222-
4541 230.
- 4542 533. Darby AE, Dimarco JP. Management of atrial fibrillation in patients with structural heart
4543 disease. *Circulation* 2012;**125**:945-957.
- 4544 534. Elkayam U. Calcium channel blockers in heart failure. *Cardiology* 1998;**89 Suppl 1**:38-46.
- 4545 535. Goldstein RE, Boccuzzi SJ, Cruess D, Nattel S. Diltiazem increases late-onset congestive
4546 heart failure in postinfarction patients with early reduction in ejection fraction. The Adverse Experience
4547 Committee; and the Multicenter Diltiazem Postinfarction Research Group. *Circulation* 1991;**83**:52-60.
- 4548 536. Clemo HF, Wood MA, Gilligan DM, Ellenbogen KA. Intravenous amiodarone for acute heart
4549 rate control in the critically ill patient with atrial tachyarrhythmias. *Am J Cardiol* 1998;**81**:594-598.
- 4550 537. Delle Karth G, Geppert A, Neunteufl T, Priglinger U, Haumer M, Gschwandtner M,
4551 Siostrzonek P, Heinz G. Amiodarone versus diltiazem for rate control in critically ill patients with atrial
4552 tachyarrhythmias. *Crit Care Med* 2001;**29**:1149-1153.
- 4553 538. Hou ZY, Chang MS, Chen CY, Tu MS, Lin SL, Chiang HT, Woosley RL. Acute treatment of
4554 recent-onset atrial fibrillation and flutter with a tailored dosing regimen of intravenous amiodarone. A
4555 randomized, digoxin-controlled study. *Eur Heart J* 1995;**16**:521-528.

- 4556 539. National Institute for Health and Care Excellence (NICE). *Atrial fibrillation: management*.
4557 *NICE guidelines [CG180]*. <http://www.nice.org.uk/guidance/cg180/>. Date last accessed 5 May
4558 2016 Accessed 15/09/2014; <http://www.nice.org.uk/guidance/cg180/>
4559 540. Kotecha D, Manzano L, Krum H, Rosano G, Holmes J, Altman DG, Collins P, Packer M,
4560 Wikstrand J, Coats AJS, Cleland JGF, Kirchhof P, von Lueder TG, Rigby A, Andersson B, Lip GYH,
4561 van Veldhuisen DJ, Shibata MC, Wedel H, Böhm M, Flather MD, Beta-Blockers in Heart Failure
4562 Collaborative Group. Effect of age and sex on efficacy and tolerability of β blockers in patients with
4563 heart failure with reduced ejection fraction: individual patient data meta-analysis. *BMJ*
4564 2016;**353**:i1855.
- 4565 541. Ulimoen SR, Enger S, Carlson J, Platonov PG, Pripp AH, Abdelnoor M, Arnesen H, Gjesdal
4566 K, Tveit A. Comparison of four single-drug regimens on ventricular rate and arrhythmia-related
4567 symptoms in patients with permanent atrial fibrillation. *Am J Cardiol* 2013;**111**:225-230.
- 4568 542. Ulimoen SR, Enger S, Pripp AH, Abdelnoor M, Arnesen H, Gjesdal K, Tveit A. Calcium
4569 channel blockers improve exercise capacity and reduce N-terminal Pro-B-type natriuretic peptide
4570 levels compared with beta-blockers in patients with permanent atrial fibrillation. *Eur Heart J*
4571 2014;**35**:517-524.
- 4572 543. Goldberger ZD, Alexander GC. Digitalis use in contemporary clinical practice: refitting the
4573 foxglove. *JAMA Intern Med* 2014;**174**:151-154.
- 4574 544. The Digitalis Investigation Group. The effect of digoxin on mortality and morbidity in patients
4575 with heart failure. *N Engl J Med* 1997;**336**:525-533.
- 4576 545. Ahmed A, Rich MW, Fleg JL, Zile MR, Young JB, Kitzman DW, Love TE, Aronow WS, Adams
4577 KF, Jr., Gheorghiade M. Effects of digoxin on morbidity and mortality in diastolic heart failure: the
4578 ancillary digitalis investigation group trial. *Circulation* 2006;**114**:397-403.
- 4579 546. Ziff OJ, Kotecha D. Digoxin: The good and the bad. *Trends in Cardiovascular Medicine*
4580 2016:[Epub ahead of print].
- 4581 547. Turakhia MP, Santangeli P, Winkelmayr WC, Xu X, Ullal AJ, Than CT, Schmitt S, Holmes
4582 TH, Frayne SM, Phibbs CS, Yang F, Hoang DD, Ho PM, Heidenreich PA. Increased mortality
4583 associated with digoxin in contemporary patients with atrial fibrillation: findings from the TREAT-AF
4584 study. *J Am Coll Cardiol* 2014;**64**:660-668.
- 4585 548. Hallberg P, Lindback J, Lindahl B, Stenström U, Melhus H. Digoxin and mortality in atrial
4586 fibrillation: a prospective cohort study. *Eur J Clin Pharmacol* 2007;**63**:959-971.
- 4587 549. Whitbeck MG, Charnigo RJ, Khairy P, Ziada K, Bailey AL, Zegarra MM, Shah J, Morales G,
4588 Macaulay T, Sorrell VL, Campbell CL, Gurley J, Anaya P, Nasr H, Bai R, Di Biase L, Booth DC,
4589 Jondeau G, Natale A, Roy D, Smyth S, Moliterno DJ, Elayi CS. Increased mortality among patients
4590 taking digoxin--analysis from the AFFIRM study. *Eur Heart J* 2013;**34**:1481-1488.
- 4591 550. Gheorghiade M, Fonarow GC, van Veldhuisen DJ, Cleland JG, Butler J, Epstein AE, Patel K,
4592 Aban IB, Aronow WS, Anker SD, Ahmed A. Lack of evidence of increased mortality among patients
4593 with atrial fibrillation taking digoxin: findings from post hoc propensity-matched analysis of the
4594 AFFIRM trial. *Eur Heart J* 2013;**34**:1489-1497.
- 4595 551. Flory JH, Ky B, Haynes K, S MB, Munson J, Rowan C, Strom BL, Hennessy S. Observational
4596 cohort study of the safety of digoxin use in women with heart failure. *BMJ Open* 2012;**2**:e000888.
- 4597 552. Andrey JL, Romero S, Garcia-Egido A, Escobar MA, Corzo R, Garcia-Dominguez G, Lechuga
4598 V, Gomez F. Mortality and morbidity of heart failure treated with digoxin. A propensity-matched study.
4599 *Int J Clin Pract* 2011;**65**:1250-1258.
- 4600 553. Allen LA, Fonarow GC, Simon DN, Thomas LE, Marzec LN, Pokorney SD, Gersh BJ, Go AS,
4601 Hylek EM, Kowey PR, Mahaffey KW, Chang P, Peterson ED, Piccini JP, ORBIT-AF Investigators.
4602 Digoxin Use and Subsequent Outcomes Among Patients in a Contemporary Atrial Fibrillation Cohort.
4603 *J Am Coll Cardiol* 2015;**65**:2691-2698.
- 4604 554. Khand AU, Rankin AC, Martin W, Taylor J, Gemmell I, Cleland JG. Carvedilol alone or in
4605 combination with digoxin for the management of atrial fibrillation in patients with heart failure? *J Am*
4606 *Coll Cardiol* 2003;**42**:1944-1951.
- 4607 555. Farshi R, Kistner D, Sarma JS, Longmate JA, Singh BN. Ventricular rate control in chronic
4608 atrial fibrillation during daily activity and programmed exercise: a crossover open-label study of five
4609 drug regimens. *J Am Coll Cardiol* 1999;**33**:304-310.
- 4610 556. Koh KK, Kwon KS, Park HB, Baik SH, Park SJ, Lee KH, Kim EJ, Kim SH, Cho SK, Kim SS.
4611 Efficacy and safety of digoxin alone and in combination with low-dose diltiazem or betaxolol to control
4612 ventricular rate in chronic atrial fibrillation. *Am J Cardiol* 1995;**75**:88-90.
- 4613 557. Lewis RV, McMurray J, McDevitt DG. Effects of atenolol, verapamil, and xamoterol on heart
4614 rate and exercise tolerance in digitalised patients with chronic atrial fibrillation. *J Cardiovasc*
4615 *Pharmacol* 1989;**13**:1-6.

- 4616 558. Tsuneda T, Yamashita T, Fukunami M, Kumagai K, Niwano S, Okumura K, Inoue H. Rate
4617 control and quality of life in patients with permanent atrial fibrillation: the Quality of Life and Atrial
4618 Fibrillation (QOLAF) Study. *Circ J* 2006;**70**:965-970.
- 4619 559. ClinicalTrials.gov. *Rate Control Therapy Evaluation in Permanent Atrial Fibrillation (RATE-*
4620 *AF)*. <https://clinicaltrials.gov/ct2/show/NCT02391337>. Date last accessed 5 May 2016
- 4621 560. Van Gelder IC, Groenveld HF, Crijns HJ, Tuininga YS, Tijssen JG, Alings AM, Hillege HL,
4622 Bergsma-Kadijk JA, Cornel JH, Kamp O, Tukkie R, Bosker HA, Van Veldhuisen DJ, Van den Berg
4623 MP, RACE II Investigators. Lenient versus strict rate control in patients with atrial fibrillation. *N Engl J*
4624 *Med* 2010;**362**:1363-1373.
- 4625 561. Groenveld HF, Crijns HJ, Van den Berg MP, Van Sonderen E, Alings AM, Tijssen JG, Hillege
4626 HL, Tuininga YS, Van Veldhuisen DJ, Ranchor AV, Van Gelder IC, RACE II Investigators. The effect
4627 of rate control on quality of life in patients with permanent atrial fibrillation: data from the RACE II
4628 (Rate Control Efficacy in Permanent Atrial Fibrillation II) study. *J Am Coll Cardiol* 2011;**58**:1795-1803.
- 4629 562. Van Gelder IC, Wyse DG, Chandler ML, Cooper HA, Olshansky B, Hagens VE, Crijns HJ,
4630 RACE and AFFIRM Investigators. Does intensity of rate-control influence outcome in atrial fibrillation?
4631 An analysis of pooled data from the RACE and AFFIRM studies. *Europace* 2006;**8**:935-942.
- 4632 563. Queiroga A, Marshall HJ, Clune M, Gammage MD. Ablate and pace revisited: long term
4633 survival and predictors of permanent atrial fibrillation. *Heart* 2003;**89**:1035-1038.
- 4634 564. Lim KT, Davis MJ, Powell A, Arnold L, Moulden K, Bulsara M, Weerasooriya R. Ablate and
4635 pace strategy for atrial fibrillation: long-term outcome of AIRCRAFT trial. *Europace* 2007;**9**:498-505.
- 4636 565. Geelen P, Brugada J, Andries E, Brugada P. Ventricular fibrillation and sudden death after
4637 radiofrequency catheter ablation of the atrioventricular junction. *Pacing Clin Electrophysiol*
4638 1997;**20**:343-348.
- 4639 566. Wang RX, Lee HC, Hodge DO, Cha YM, Friedman PA, Rea RF, Munger TM, Jahangir A,
4640 Srivathsan K, Shen WK. Effect of pacing method on risk of sudden death after atrioventricular node
4641 ablation and pacemaker implantation in patients with atrial fibrillation. *Heart Rhythm* 2013;**10**:696-701.
- 4642 567. Chatterjee NA, Upadhyay GA, Ellenbogen KA, McAlister FA, Choudhry NK, Singh JP.
4643 Atrioventricular nodal ablation in atrial fibrillation: a meta-analysis and systematic review. *Circ*
4644 *Arrhythm Electrophysiol* 2012;**5**:68-76.
- 4645 568. Bradley DJ, Shen WK. Overview of management of atrial fibrillation in symptomatic elderly
4646 patients: pharmacologic therapy versus AV node ablation. *Clin Pharmacol Ther* 2007;**81**:284-287.
- 4647 569. Wood MA, Brown-Mahoney C, Kay GN, Ellenbogen KA. Clinical outcomes after ablation and
4648 pacing therapy for atrial fibrillation : a meta-analysis. *Circulation* 2000;**101**:1138-1144.
- 4649 570. Ozcan C, Jahangir A, Friedman PA, Patel PJ, Munger TM, Rea RF, Lloyd MA, Packer DL,
4650 Hodge DO, Gersh BJ, Hammill SC, Shen WK. Long-term survival after ablation of the atrioventricular
4651 node and implantation of a permanent pacemaker in patients with atrial fibrillation. *N Engl J Med*
4652 2001;**344**:1043-1051.
- 4653 571. Hess PL, Jackson KP, Hasselblad V, Al-Khatib SM. Is cardiac resynchronization therapy an
4654 antiarrhythmic therapy for atrial fibrillation? A systematic review and meta-analysis. *Curr Cardiol Rep*
4655 2013;**15**:330.
- 4656 572. Hoppe UC, Casares JM, Eiskjaer H, Hagemann A, Cleland JG, Freemantle N, Erdmann E.
4657 Effect of cardiac resynchronization on the incidence of atrial fibrillation in patients with severe heart
4658 failure. *Circulation* 2006;**114**:18-25.
- 4659 573. Brignole M, Auricchio A, Baron-Esquivias G, Bordachar P, Boriani G, Breithardt OA, Cleland
4660 J, Deharo JC, Delgado V, Elliott PM, Gorenek B, Israel CW, Leclercq C, Linde C, Mont L, Padeletti L,
4661 Sutton R, Vardas PE, Zamorano JL, Achenbach S, Baumgartner H, Bax JJ, Bueno H, Dean V,
4662 Deaton C, Erol C, Fagard R, Ferrari R, Hasdai D, Hoes AW, Kirchhof P, Knuuti J, Kolh P, Lancellotti
4663 P, Linhart A, Nihoyannopoulos P, Piepoli MF, Ponikowski P, Sirnes PA, Tamargo JL, Tendra M,
4664 Torbicki A, Wijns W, Windecker S, Kirchhof P, Blomstrom-Lundqvist C, Badano LP, Aliyev F, Bansch
4665 D, Baumgartner H, Bsata W, Buser P, Charron P, Daubert JC, Dobreanu D, Faerstrand S, Hasdai D,
4666 Hoes AW, Le Heuzey JY, Mavrakis H, McDonagh T, Merino JL, Nawar MM, Nielsen JC, Pieske B,
4667 Poposka L, Ruschitzka F, Tendra M, Van Gelder IC, Wilson CM. 2013 ESC Guidelines on cardiac
4668 pacing and cardiac resynchronization therapy: the Task Force on cardiac pacing and
4669 resynchronization therapy of the European Society of Cardiology (ESC). Developed in collaboration
4670 with the European Heart Rhythm Association (EHRA). *Eur Heart J* 2013;**34**:2281-2329.
- 4671 574. Chatterjee NA, Upadhyay GA, Ellenbogen KA, Hayes DL, Singh JP. Atrioventricular nodal
4672 ablation in atrial fibrillation: a meta-analysis of biventricular vs. right ventricular pacing mode. *Eur J*
4673 *Heart Fail* 2012;**14**:661-667.

- 4674 575. Lewis RV, Irvine N, McDevitt DG. Relationships between heart rate, exercise tolerance and
4675 cardiac output in atrial fibrillation: the effects of treatment with digoxin, verapamil and diltiazem. *Eur*
4676 *Heart J* 1988;**9**:777-781.
- 4677 576. Mulder BA, Van Veldhuisen DJ, Crijns HJ, Tijssen JG, Hillege HL, Alings M, Rienstra M, Van
4678 den Berg MP, Van Gelder IC, RACE II Investigators. Digoxin in patients with permanent atrial
4679 fibrillation: data from the RACE II study. *Heart Rhythm* 2014;**11**:1543-1550.
- 4680 577. Koh KK, Song JH, Kwon KS, Park HB, Baik SH, Park YS, In HH, Moon TH, Park GS, Cho SK,
4681 Kim SS. Comparative study of efficacy and safety of low-dose diltiazem or betaxolol in combination
4682 with digoxin to control ventricular rate in chronic atrial fibrillation: randomized crossover study. *Int J*
4683 *Cardiol* 1995;**52**:167-174.
- 4684 578. Chatterjee S, Sardar P, Lichstein E, Mukherjee D, Aikat S. Pharmacologic rate versus rhythm-
4685 control strategies in atrial fibrillation: an updated comprehensive review and meta-analysis. *PACE*
4686 2013;**36**:122-133.
- 4687 579. de Denus S, Sanoski CA, Carlsson J, Opolski G, Spinler SA. Rate vs rhythm control in
4688 patients with atrial fibrillation: a meta-analysis. *Arch Intern Med* 2005;**165**:258-262.
- 4689 580. Lafuente-Lafuente C, Longas-Tejero MA, Bergmann JF, Belmin J. Antiarrhythmics for
4690 maintaining sinus rhythm after cardioversion of atrial fibrillation. *Cochrane Database Syst Rev*
4691 2012;**5**:CD005049.
- 4692 581. Roy D, Talajic M, Dorian P, Connolly S, Eisenberg MJ, Green M, Kus T, Lambert J, Dubuc M,
4693 Gagne P, Nattel S, Thibault B. Amiodarone to prevent recurrence of atrial fibrillation. Canadian Trial of
4694 Atrial Fibrillation Investigators. *N Engl J Med* 2000;**342**:913-920.
- 4695 582. Roy D, Talajic M, Nattel S, Wyse DG, Dorian P, Lee KL, Bourassa MG, Arnold JM, Buxton
4696 AE, Camm AJ, Connolly SJ, Dubuc M, Ducharme A, Guerra PG, Hohnloser SH, Lambert J, Le
4697 Heuzey JY, O'Hara G, Pedersen OD, Rouleau JL, Singh BN, Stevenson LW, Stevenson WG, Thibault
4698 B, Waldo AL. Rhythm control versus rate control for atrial fibrillation and heart failure. *N Engl J Med*
4699 2008;**358**:2667-2677.
- 4700 583. Singh BN, Connolly SJ, Crijns HJ, Roy D, Kowey PR, Capucci A, Radzik D, Aliot EM,
4701 Hohnloser SH. Dronedarone for maintenance of sinus rhythm in atrial fibrillation or flutter. *N Engl J*
4702 *Med* 2007;**357**:987-999.
- 4703 584. Kirchhof P, Andresen D, Bosch R, Borggrefe M, Meinertz T, Parade U, Ravens U, Samol A,
4704 Steinbeck G, Treszl A, Wegscheider K, Breithardt G. Short-term versus long-term antiarrhythmic drug
4705 treatment after cardioversion of atrial fibrillation (Flec-SL): a prospective, randomised, open-label,
4706 blinded endpoint assessment trial. *Lancet* 2012;**380**:238-246.
- 4707 585. Cosedis Nielsen J, Johannessen A, Raatikainen P, Hindricks G, Walfridsson H, Kongstad O,
4708 Pehrson S, Englund A, Hartikainen J, Mortensen LS, Hansen PS. Radiofrequency ablation as initial
4709 therapy in paroxysmal atrial fibrillation. *N Engl J Med* 2012;**367**:1587-1595.
- 4710 586. Wilber DJ, Pappone C, Neuzil P, De Paola A, Marchlinski F, Natale A, Macle L, Daoud EG,
4711 Calkins H, Hall B, Reddy V, Augello G, Reynolds MR, Vinekar C, Liu CY, Berry SM, Berry DA,
4712 ThermoCool AF Trial Investigators. Comparison of antiarrhythmic drug therapy and radiofrequency
4713 catheter ablation in patients with paroxysmal atrial fibrillation: a randomized controlled trial. *JAMA*
4714 2010;**303**:333-340.
- 4715 587. Arbelo E, Brugada J, Hindricks G, Maggioni AP, Tavazzi L, Vardas P, Laroche C, Anselme F,
4716 Inama G, Jais P, Kalarus Z, Kautzner J, Lewalter T, Mairesse GH, Perez-Villacastin J, Riahi S,
4717 Taborsky M, Theodorakis G, Trines SA, Atrial Fibrillation Ablation Pilot Study Investigators. The atrial
4718 fibrillation ablation pilot study: a European Survey on Methodology and results of catheter ablation for
4719 atrial fibrillation conducted by the European Heart Rhythm Association. *Eur Heart J* 2014;**35**:1466-
4720 1478.
- 4721 588. Hohnloser SH, Crijns HJ, van Eickels M, Gaudin C, Page RL, Torp-Pedersen C, Connolly SJ.
4722 Effect of dronedarone on cardiovascular events in atrial fibrillation. *N Engl J Med* 2009;**360**:668-678.
- 4723 589. Wyse DG, Waldo AL, DiMarco JP, Domanski MJ, Rosenberg Y, Schron EB, Kellen JC,
4724 Greene HL, Mickel MC, Dalquist JE, Corley SD. A comparison of rate control and rhythm control in
4725 patients with atrial fibrillation. *N Engl J Med* 2002;**347**:1825-1833.
- 4726 590. Van Gelder IC, Hagens VE, Bosker HA, Kingma JH, Kamp O, Kingma T, Said SA, Darmanata
4727 JI, Timmermans AJ, Tijssen JG, Crijns HJ, Rate Control versus Electrical Cardioversion for Persistent
4728 Atrial Fibrillation Study Group. A comparison of rate control and rhythm control in patients with
4729 recurrent persistent atrial fibrillation. *N Engl J Med* 2002;**347**:1834-1840.
- 4730 591. Opolski G, Torbicki A, Kosior DA, Szulc M, Wozakowska-Kaplon B, Kolodziej P, Achremczyk
4731 P, Investigators of the Polish How to Treat Chronic Atrial Fibrillation Study. Rate control vs rhythm
4732 control in patients with nonvalvular persistent atrial fibrillation: the results of the Polish How to Treat
4733 Chronic Atrial Fibrillation (HOT CAFE) Study. *Chest* 2004;**126**:476-486.

- 4734 592. Kong MH, Shaw LK, O'Connor C, Califf RM, Blazing MA, Al-Khatib SM. Is rhythm-control
4735 superior to rate-control in patients with atrial fibrillation and diastolic heart failure? *Ann Noninvasive*
4736 *Electrocardiol* 2010;**15**:209-217.
- 4737 593. Kotecha D, Kirchhof P. Rate and rhythm control have comparable effects on mortality and
4738 stroke in atrial fibrillation but better data are needed. *Evid Based Med* 2014;**19**:222-223.
- 4739 594. ClinicalTrials.gov. *Catheter Ablation vs Anti-arrhythmic Drug Therapy for Atrial Fibrillation*
4740 *Trial (CABANA)*. <https://clinicaltrials.gov/ct2/show/NCT00911508>. Date last accessed 5 May
4741 2016 NLM Identifier: NCT00911508 [Accessed 20-May-2015]
- 4742 595. Khan IA. Oral loading single dose flecainide for pharmacological cardioversion of recent-onset
4743 atrial fibrillation. *Int J Cardiol* 2003;**87**:121-128.
- 4744 596. Chevalier P, Durand-Dubief A, Burri H, Cucherat M, Kirkorian G, Touboul P. Amiodarone
4745 versus placebo and class Ic drugs for cardioversion of recent-onset atrial fibrillation: a meta-analysis.
4746 *J Am Coll Cardiol* 2003;**41**:255-262.
- 4747 597. Letelier LM, Udol K, Ena J, Weaver B, Guyatt GH. Effectiveness of amiodarone for
4748 conversion of atrial fibrillation to sinus rhythm: a meta-analysis. *Arch Intern Med* 2003;**163**:777-785.
- 4749 598. Khan IA, Mehta NJ, Gowda RM. Amiodarone for pharmacological cardioversion of recent-
4750 onset atrial fibrillation. *Int J Cardiol* 2003;**89**:239-248.
- 4751 599. Thomas SP, Guy D, Wallace E, Crompton R, Kijvanit P, Eipper V, Ross DL, Cooper MJ.
4752 Rapid loading of sotalol or amiodarone for management of recent onset symptomatic atrial fibrillation:
4753 a randomized, digoxin-controlled trial. *Am Heart J* 2004;**147**:E3.
- 4754 600. Vijayalakshmi K, Whittaker VJ, Sutton A, Campbell P, Wright RA, Hall JA, Harcombe AA,
4755 Linker NJ, Stewart MJ, Davies A, de Belder MA. A randomized trial of prophylactic antiarrhythmic
4756 agents (amiodarone and sotalol) in patients with atrial fibrillation for whom direct current cardioversion
4757 is planned. *Am Heart J* 2006;**151**:863 e861-866.
- 4758 601. Singh BN, Singh SN, Reda DJ, Tang XC, Lopez B, Harris CL, Fletcher RD, Sharma SC,
4759 Atwood JE, Jacobson AK, Lewis HD, Jr., Raisch DW, Ezekowitz MD. Amiodarone versus sotalol for
4760 atrial fibrillation. *N Engl J Med* 2005;**352**:1861-1872.
- 4761 602. Roy D, Pratt CM, Torp-Pedersen C, Wyse DG, Toft E, Juul-Moller S, Nielsen T, Rasmussen
4762 SL, Stiell IG, Coutu B, Ip JH, Pritchett EL, Camm AJ. Vernakalant hydrochloride for rapid conversion
4763 of atrial fibrillation: a phase 3, randomized, placebo-controlled trial. *Circulation* 2008;**117**:1518-1525.
- 4764 603. Kowey PR, Dorian P, Mitchell LB, Pratt CM, Roy D, Schwartz PJ, Sadowski J, Sobczyk D,
4765 Bochenek A, Toft E. Vernakalant hydrochloride for the rapid conversion of atrial fibrillation after
4766 cardiac surgery: a randomized, double-blind, placebo-controlled trial. *Circ Arrhythm Electrophysiol*
4767 2009;**2**:652-659.
- 4768 604. Camm AJ, Capucci A, Hohnloser SH, Torp-Pedersen C, Van Gelder IC, Mangal B, Beatch G.
4769 A randomized active-controlled study comparing the efficacy and safety of vernakalant to amiodarone
4770 in recent-onset atrial fibrillation. *J Am Coll Cardiol* 2011;**57**:313-321.
- 4771 605. Bash LD, Buono JL, Davies GM, Martin A, Fahrbach K, Phatak H, Avetisyan R, Mwamburi M.
4772 Systematic review and meta-analysis of the efficacy of cardioversion by vernakalant and comparators
4773 in patients with atrial fibrillation. *Cardiovasc Drugs Ther* 2012;**26**:167-179.
- 4774 606. Falk RH, Pollak A, Singh SN, Friedrich T. Intravenous dofetilide, a class III antiarrhythmic
4775 agent, for the termination of sustained atrial fibrillation or flutter. Intravenous Dofetilide Investigators
4776 [see comments]. *J Am Coll Cardiol* 1997;**29**:385-390.
- 4777 607. Dankner R, Shahar A, Novikov I, Agmon U, Ziv A, Hod H. Treatment of stable atrial fibrillation
4778 in the emergency department: a population-based comparison of electrical direct-current versus
4779 pharmacological cardioversion or conservative management. *Cardiology* 2009;**112**:270-278.
- 4780 608. Chen WS, Gao BR, Chen WQ, Li ZZ, Xu ZY, Zhang YH, Yang K, Guan XQ. Comparison of
4781 pharmacological and electrical cardioversion in permanent atrial fibrillation after prosthetic cardiac
4782 valve replacement: a prospective randomized trial. *J Int Med Res* 2013;**41**:1067-1073.
- 4783 609. Gitt AK, Smolka W, Michailov G, Bernhardt A, Pittrow D, Lewalter T. Types and outcomes of
4784 cardioversion in patients admitted to hospital for atrial fibrillation: results of the German RHYTHM-AF
4785 Study. *Clin Res Cardiol* 2013;**102**:713-723.
- 4786 610. Cristoni L, Tampieri A, Mucci F, Iannone P, Venturi A, Cavazza M, Lenzi T. Cardioversion of
4787 acute atrial fibrillation in the short observation unit: comparison of a protocol focused on electrical
4788 cardioversion with simple antiarrhythmic treatment. *Emerg Med J* 2011;**28**:932-937.
- 4789 611. Bellone A, Eteri M, Vettorello M, Bonetti C, Clerici D, Gini G, Maino C, Mariani M, Natalizi A,
4790 Nessi I, Rampoldi A, Colombo L. Cardioversion of acute atrial fibrillation in the emergency
4791 department: a prospective randomised trial. *Emerg Med J* 2012;**29**:188-191.
- 4792 612. Crijns HJ, Weijs B, Fairley AM, Lewalter T, Maggioni AP, Martin A, Ponikowski P, Rosenqvist
4793 M, Sanders P, Scanavacca M, Bash LD, Chazelle F, Bernhardt A, Gitt AK, Lip GY, Le Heuzey JY.

- 4794 Contemporary real life cardioversion of atrial fibrillation: Results from the multinational RHYTHM-AF
4795 study. *Int J Cardiol* 2014;**172**:588-594.
- 4796 613. Lip GY, Gitt AK, Le Heuzey JY, Bash LD, Morabito CJ, Bernhardt AA, Sisk CM, Chazelle F,
4797 Crijns HJ. Overtreatment and undertreatment with anticoagulation in relation to cardioversion of atrial
4798 fibrillation (the RHYTHM-AF study). *Am J Cardiol* 2014;**113**:480-484.
- 4799 614. Reisinger J, Gatterer E, Lang W, Vanicek T, Eisserer G, Bachleitner T, Niemeth C, Aicher F,
4800 Grander W, Heinze G, Kuhn P, Siostrzonek P. Flecainide versus ibutilide for immediate cardioversion
4801 of atrial fibrillation of recent onset. *Eur Heart J* 2004;**25**:1318-1324.
- 4802 615. Stambler BS, Wood MA, Ellenbogen KA, Perry KT, Wakefield LK, VanderLugt JT. Efficacy
4803 and safety of repeated intravenous doses of ibutilide for rapid conversion of atrial flutter or fibrillation.
4804 Ibutilide Repeat Dose Study Investigators. *Circulation* 1996;**94**:1613-1621.
- 4805 616. Torp-Pedersen C, Camm AJ, Butterfield NN, Dickinson G, Beatch GN. Vernakalant:
4806 conversion of atrial fibrillation in patients with ischemic heart disease. *Int J Cardiol* 2013;**166**:147-151.
- 4807 617. Savelieva I, Graydon R, Camm AJ. Pharmacological cardioversion of atrial fibrillation with
4808 vernakalant: evidence in support of the ESC Guidelines. *Europace* 2014;**16**:162-173.
- 4809 618. Simon A, Niederdoeckl J, Skyllouriotis E, Schuetz N, Herkner H, Weiser C, Laggner AN,
4810 Domanovits H, Spiel AO. Vernakalant is superior to ibutilide for achieving sinus rhythm in patients
4811 with recent-onset atrial fibrillation: a randomized controlled trial at the emergency department.
4812 *Europace* 2016;**10.1093/europace/euw052**: [Epub ahead of print].
- 4813 619. Reisinger J, Gatterer E, Heinze G, Wiesinger K, Zeindlhofer E, Gattermeier M, Poelzl G,
4814 Kratzer H, Ebner A, Hohenwallner W, Lenz K, Slany J, Kuhn P. Prospective comparison of flecainide
4815 versus sotalol for immediate cardioversion of atrial fibrillation. *Am J Cardiol* 1998;**81**:1450-1454.
- 4816 620. Alboni P, Botto GL, Baldi N, Luzi M, Russo V, Gianfranchi L, Marchi P, Calzolari M, Solano A,
4817 Baroffio R, Gaggioli G. Outpatient treatment of recent-onset atrial fibrillation with the "pill-in-the-
4818 pocket" approach. *N Engl J Med* 2004;**351**:2384-2391.
- 4819 621. Saborido CM, Hockenhull J, Bagust A, Boland A, Dickson R, Todd D. Systematic review and
4820 cost-effectiveness evaluation of 'pill-in-the-pocket' strategy for paroxysmal atrial fibrillation compared
4821 to episodic in-hospital treatment or continuous antiarrhythmic drug therapy. *Health Technol Assess*
4822 2010;**14**:iii-iv, 1-75.
- 4823 622. Khan IA. Single oral loading dose of propafenone for pharmacological cardioversion of recent-
4824 onset atrial fibrillation. *J Am Coll Cardiol* 2001;**37**:542-547.
- 4825 623. Stroobandt R, Stiels B, Hoebrechts R. Propafenone for conversion and prophylaxis of atrial
4826 fibrillation. Propafenone Atrial Fibrillation Trial Investigators. *Am J Cardiol* 1997;**79**:418-423.
- 4827 624. Hughes C, Sunderji R, Gin K. Oral propafenone for rapid conversion of recent onset atrial
4828 fibrillation - A review. *CAN J CARDIOL. Canadian Journal of Cardiology* 1997;**13**:839-842.
- 4829 625. Zhang N, Guo JH, Zhang H, Li XB, Zhang P, Xn Y. Comparison of intravenous ibutilide vs.
4830 propafenone for rapid termination of recent onset atrial fibrillation. *Int J Clin Pract* 2005;**59**:1395-1400.
- 4831 626. Mittal S, Ayati S, Stein KM, Schwartzman D, Cavlovich D, Tchou PJ, Markowitz SM, Slotwiner
4832 DJ, Scheiner MA, Lerman BB. Transthoracic cardioversion of atrial fibrillation: comparison of
4833 rectilinear biphasic versus damped sine wave monophasic shocks. *Circulation* 2000;**101**:1282-1287.
- 4834 627. Kirchhof P, Eckardt L, Loh P, Weber K, Fischer RJ, Seidl KH, Böcker D, Breithardt G,
4835 Haverkamp W, Borggrefe M. Anterior-posterior versus anterior-lateral electrode positions for external
4836 cardioversion of atrial fibrillation: a randomised trial. *Lancet* 2002;**360**:1275-1279.
- 4837 628. Kirchhof P, Monnig G, Wasmer K, Heinecke A, Breithardt G, Eckardt L, Bocker D. A trial of
4838 self-adhesive patch electrodes and hand-held paddle electrodes for external cardioversion of atrial
4839 fibrillation (MOBIPAPA). *Eur Heart J* 2005;**26**:1292-1297.
- 4840 629. Furniss SS, Sneyd JR. Safe sedation in modern cardiological practice. *Heart* 2015;**101**:1526-
4841 1530.
- 4842 630. Alp N, Rahman S, Bell J, Shahi M. Randomised comparison of antero-lateral versus antero-
4843 posterior paddle positions for DC cardioversion of persistent atrial fibrillation. *Int J Cardiol*
4844 2000;**75**:211-216.
- 4845 631. Singh SN, Tang XC, Reda D, Singh BN. Systematic electrocardioversion for atrial fibrillation
4846 and role of antiarrhythmic drugs: a substudy of the SAFE-T trial. *Heart Rhythm* 2009;**6**:152-155.
- 4847 632. Channer KS, Birchall A, Steeds RP, Walters SJ, Yeo WW, West JN, Muthusamy R, Rhoden
4848 WE, Saeed BT, Batin P, Brooksby WP, Wilson I, Grant S. A randomized placebo-controlled trial of
4849 pre-treatment and short- or long-term maintenance therapy with amiodarone supporting DC
4850 cardioversion for persistent atrial fibrillation. *Eur Heart J* 2004;**25**:144-150.
- 4851 633. Oral H, Souza JJ, Michaud GF, Knight BP, Goyal R, Strickberger SA, Morady F. Facilitating
4852 transthoracic cardioversion of atrial fibrillation with ibutilide pretreatment. *N Engl J Med*
4853 1999;**340**:1849-1854.

- 4854 634. Mussigbrodt A, John S, Kosiuk J, Richter S, Hindricks G, Bollmann A. Vernakalant-facilitated
4855 electrical cardioversion: comparison of intravenous vernakalant and amiodarone for drug-enhanced
4856 electrical cardioversion of atrial fibrillation after failed electrical cardioversion. *Europace* 2016;**18**:51-
4857 56.
- 4858 635. Bianconi L, Mennuni M, Lukic V, Castro A, Chieffi M, Santini M. Effects of oral propafenone
4859 administration before electrical cardioversion of chronic atrial fibrillation: a placebo-controlled study. *J*
4860 *Am Coll Cardiol* 1996;**28**:700-706.
- 4861 636. Nergårdh AK, Rosenqvist M, Nordlander R, Frick M. Maintenance of sinus rhythm with
4862 metoprolol CR initiated before cardioversion and repeated cardioversion of atrial fibrillation: a
4863 randomized double-blind placebo-controlled study. *Eur Heart J* 2007;**28**:1351-1357.
- 4864 637. Hemels ME, Van Noord T, Crijns HJ, Van Veldhuisen DJ, Veeger NJ, Bosker HA, Wiesfeld
4865 AC, Van den Berg MP, Ranchor AV, Van Gelder IC. Verapamil versus digoxin and acute versus
4866 routine serial cardioversion for the improvement of rhythm control for persistent atrial fibrillation. *J Am*
4867 *Coll Cardiol* 2006;**48**:1001-1009.
- 4868 638. Villani GQ, Piepoli MF, Terracciano C, Capucci A. Effects of diltiazem pretreatment on direct-
4869 current cardioversion in patients with persistent atrial fibrillation: a single-blind, randomized, controlled
4870 study. *Am Heart J* 2000;**140**:e12.
- 4871 639. De Simone A, Stabile G, Vitale DF, Turco P, Di Stasio M, Petrazzuoli F, Gasparini M, De
4872 Matteis C, Rotunno R, Di Napoli T. Pretreatment with verapamil in patients with persistent or chronic
4873 atrial fibrillation who underwent electrical cardioversion. *J Am Coll Cardiol* 1999;**34**:810-814.
- 4874 640. The Digitalis in Acute Atrial Fibrillation (DAAF) Trial Group. Intravenous digoxin in acute atrial
4875 fibrillation. Results of a randomized, placebo-controlled multicentre trial in 239 patients. *Eur Heart J*
4876 1997;**18**:649-654.
- 4877 641. Atarashi H, Inoue H, Fukunami M, Sugi K, Hamada C, Origasa H. Double-blind placebo-
4878 controlled trial of aprindine and digoxin for the prevention of symptomatic atrial fibrillation. *Circ J*
4879 2002;**66**:553-556.
- 4880 642. Airaksinen KE, Gronberg T, Nuotio I, Nikkinen M, Ylitalo A, Biancari F, Hartikainen JE.
4881 Thromboembolic complications after cardioversion of acute atrial fibrillation: the FinCV (Finnish
4882 CardioVersion) study. *J Am Coll Cardiol* 2013;**62**:1187-1192.
- 4883 643. Hansen ML, Jepsen RM, Olesen JB, Ruwald MH, Karasoy D, Gislason GH, Hansen J, Kober
4884 L, Husted S, Torp-Pedersen C. Thromboembolic risk in 16 274 atrial fibrillation patients undergoing
4885 direct current cardioversion with and without oral anticoagulant therapy. *Europace* 2015;**17**:18-23.
- 4886 644. Schädlich PK, Schmidt-Lucke C, Huppertz E, Lehmacher W, Nixdorff U, Stellbrink C, Brecht
4887 JG. Economic evaluation of enoxaparin for anticoagulation in early cardioversion of persisting
4888 nonvalvular atrial fibrillation: a statutory health insurance perspective from Germany. *Am J Cardiovasc*
4889 *Drugs* 2007;**7**:199-217.
- 4890 645. Schmidt-Lucke C, Paar WD, Stellbrink C, Nixdorff U, Hofmann T, Meurer J, Grewe R, Daniel
4891 WG, Hanrath P, Mugge A, Klein HU, Schmidt-Lucke JA. Quality of anticoagulation with unfractionated
4892 heparin plus phenprocoumon for the prevention of thromboembolic complications in cardioversion for
4893 non-valvular atrial fibrillation. Sub-analysis from the Anticoagulation in Cardioversion using
4894 Enoxaparin (ACE) trial. *Thromb Res* 2007;**119**:27-34.
- 4895 646. Stellbrink C, Nixdorff U, Hofmann T, Lehmacher W, Daniel WG, Hanrath P, Geller C, Mugge
4896 A, Sehnert W, Schmidt-Lucke C, Schmidt-Lucke JA. Safety and efficacy of enoxaparin compared with
4897 unfractionated heparin and oral anticoagulants for prevention of thromboembolic complications in
4898 cardioversion of nonvalvular atrial fibrillation: the Anticoagulation in Cardioversion using Enoxaparin
4899 (ACE) trial. *Circulation* 2004;**109**:997-1003.
- 4900 647. Nuotio I, Hartikainen JE, Gronberg T, Biancari F, Airaksinen KE. Time to cardioversion for
4901 acute atrial fibrillation and thromboembolic complications. *JAMA* 2014;**312**:647-649.
- 4902 648. Klein AL, Grimm RA, Murray RD, Apperson-Hansen C, Asinger RW, Black IW, Davidoff R,
4903 Erbel R, Halperin JL, Orsinelli DA, Porter TR, Stoddard MF. Use of transesophageal
4904 echocardiography to guide cardioversion in patients with atrial fibrillation. *N Engl J Med*
4905 2001;**344**:1411-1420.
- 4906 649. Cappato R, Ezekowitz MD, Klein AL, Camm AJ, Ma CS, Le Heuzey JY, Talajic M,
4907 Scanavacca M, Vardas PE, Kirchhof P, Hemmrich M, Lanius V, Meng IL, Wildgoose P, van Eickels M,
4908 Hohnloser SH, Investigators XV. Rivaroxaban vs. vitamin K antagonists for cardioversion in atrial
4909 fibrillation. *Eur Heart J* 2014;**35**:3346-3355.
- 4910 650. Darkner S, Chen X, Hansen J, Pehrson S, Johannessen A, Nielsen JB, Svendsen JH.
4911 Recurrence of arrhythmia following short-term oral AMIODARONE after CATHETER ablation for atrial
4912 fibrillation: a double-blind, randomized, placebo-controlled study (AMIO-CAT trial). *Eur Heart J*
4913 2014;**35**:3356-3364.

- 4914 651. Singh SN, Fletcher RD, Fisher SG, Singh BN, Lewis HD, Deedwania PC, Massie BM, Colling
4915 C, Lazzeri D. Amiodarone in patients with congestive heart failure and asymptomatic ventricular
4916 arrhythmia. Survival Trial of Antiarrhythmic Therapy in Congestive Heart Failure. *N Engl J Med*
4917 1995;**333**:77-82.
- 4918 652. Kirchhof P, Franz MR, Bardai A, Wilde AM. Giant T-U waves precede torsades de pointes in
4919 long QT syndrome: a systematic electrocardiographic analysis in patients with acquired and
4920 congenital QT prolongation. *J Am Coll Cardiol* 2009;**54**:143-149.
- 4921 653. Goldschlager N, Epstein AE, Naccarelli GV, Olshansky B, Singh B, Collard HR, Murphy E. A
4922 practical guide for clinicians who treat patients with amiodarone: 2007. *Heart Rhythm* 2007;**4**:1250-
4923 1259.
- 4924 654. Wolkove N, Baltzan M. Amiodarone pulmonary toxicity. *Can Respir J* 2009;**16**:43-48.
- 4925 655. Ahmed S, Rienstra M, Crijns HJ, Links TP, Wiesfeld AC, Hillege HL, Bosker HA, Lok DJ, Van
4926 Veldhuisen DJ, Van Gelder IC. Continuous vs episodic prophylactic treatment with amiodarone for the
4927 prevention of atrial fibrillation: a randomized trial. *JAMA* 2008;**300**:1784-1792.
- 4928 656. Davy JM, Herold M, Hognlund C, Timmermans A, Alings A, Radzik D, Van Kempen L.
4929 Dronedarone for the control of ventricular rate in permanent atrial fibrillation: the Efficacy and safety of
4930 dRonedArone for the cOntrol of ventricular rate during atrial fibrillation (ERATO) study. *Am Heart J*
4931 2008;**156**:527 e521-529.
- 4932 657. Kober L, Torp-Pedersen C, McMurray JJ, Gotzsche O, Levy S, Crijns H, Amlie J, Carlsen J,
4933 Dronedarone Study Group. Increased mortality after dronedarone therapy for severe heart failure. *N*
4934 *Engl J Med* 2008;**358**:2678-2687.
- 4935 658. Connolly SJ, Camm AJ, Halperin JL, Joyner C, Alings M, Amerena J, Atar D, Avezum A,
4936 Blomstrom P, Borggrefe M, Budaj A, Chen SA, Ching CK, Commerford P, Dans A, Davy JM,
4937 Delacretaz E, Di Pasquale G, Diaz R, Dorian P, Flaker G, Golitsyn S, Gonzalez-Hermosillo A,
4938 Granger CB, Heidbuchel H, Kautzner J, Kim JS, Lanan F, Lewis BS, Merino JL, Morillo C, Murin J,
4939 Narasimhan C, Paolasso E, Parkhomenko A, Peters NS, Sim KH, Stiles MK, Tanomsup S, Toivonen
4940 L, Tomcsanyi J, Torp-Pedersen C, Tse HF, Vardas P, Vinereanu D, Xavier D, Zhu J, Zhu JR, Baret-
4941 Cormel L, Weinling E, Staiger C, Yusuf S, Chrolavicius S, Afzal R, Hohnloser SH. Dronedarone in
4942 high-risk permanent atrial fibrillation. *N Engl J Med* 2011;**365**:2268-2276.
- 4943 659. Tschuppert Y, Buclin T, Rothuizen LE, Decosterd LA, Galleyrand J, Gaud C, Biollaz J. Effect
4944 of dronedarone on renal function in healthy subjects. *Br J Clin Pharmacol* 2007;**64**:785-791.
- 4945 660. The Cardiac Arrhythmia Suppression Trial (CAST) Investigators. Preliminary report: effect of
4946 encainide and flecainide on mortality in a randomized trial of arrhythmia suppression after myocardial
4947 infarction. *N Engl J Med* 1989;**321**:406-412.
- 4948 661. Freemantle N, Lafuente-Lafuente C, Mitchell S, Eckert L, Reynolds M. Mixed treatment
4949 comparison of dronedarone, amiodarone, sotalol, flecainide, and propafenone, for the management of
4950 atrial fibrillation. *Europace* 2011;**13**:329-345.
- 4951 662. Sherrid MV, Barac I, McKenna WJ, Elliott PM, Dickie S, Chojnowska L, Casey S, Maron BJ.
4952 Multicenter study of the efficacy and safety of disopyramide in obstructive hypertrophic
4953 cardiomyopathy. *J Am Coll Cardiol* 2005;**45**:1251-1258.
- 4954 663. Sirak TE, Sherrid MV. Oral disopyramide for the acute treatment of severe outflow obstruction
4955 in hypertrophic cardiomyopathy in the ICU setting. *Chest* 2008;**133**:1243-1246.
- 4956 664. Sherrid MV, Shetty A, Winson G, Kim B, Musat D, Alviar CL, Homel P, Balaram SK, Swistel
4957 DG. Treatment of obstructive hypertrophic cardiomyopathy symptoms and gradient resistant to first-
4958 line therapy with beta-blockade or verapamil. *Circ Heart Fail* 2013;**6**:694-702.
- 4959 665. Waldo AL, Camm AJ, deRuyter H, Friedman PL, MacNeil DJ, Pauls JF, Pitt B, Pratt CM,
4960 Schwartz PJ, Veltri EP. Effect of d-sotalol on mortality in patients with left ventricular dysfunction after
4961 recent and remote myocardial infarction. The SWORD Investigators. Survival With Oral d-Sotalol.
4962 *Lancet* 1996;**348**:7-12.
- 4963 666. Pedersen OD, Bagger H, Keller N, Marchant B, Kober L, Torp-Pedersen C. Efficacy of
4964 dofetilide in the treatment of atrial fibrillation-flutter in patients with reduced left ventricular function: a
4965 Danish investigations of arrhythmia and mortality on dofetilide (diamond) substudy. *Circulation*
4966 2001;**104**:292-296.
- 4967 667. Shamiss Y, Khaykin Y, Oosthuizen R, Tunney D, Sarak B, Beardsall M, Seabrook C, Frost L,
4968 Wulffhart Z, Tsang B, Verma A. Dofetilide is safe and effective in preventing atrial fibrillation
4969 recurrences in patients accepted for catheter ablation. *Europace* 2009;**11**:1448-1455.
- 4970 668. Haverkamp W, Breithardt G, Camm AJ, Janse MJ, Rosen MR, Antzelevitch C, Escande D,
4971 Franz M, Malik M, Moss A, Shah R. The potential for QT prolongation and pro-arrhythmia by non-anti-
4972 arrhythmic drugs: clinical and regulatory implications. Report on a Policy Conference of the European
4973 Society of Cardiology. *Cardiovasc Res* 2000;**47**:219-233.

- 4974 669. Käab S, Hinterseer M, Näbauer M, Steinbeck G. Sotalol testing unmasks altered
4975 repolarization in patients with suspected acquired long-QT-syndrome-a case-control pilot study using
4976 i.v. sotalol. *Eur Heart J* 2003;**24**:649-657.
- 4977 670. Fabritz L, Kirchhof P. Predictable and less predictable unwanted cardiac drugs effects:
4978 individual pre-disposition and transient precipitating factors. *Basic Clin Pharmacol Toxicol*
4979 2010;**106**:263-268.
- 4980 671. Choy AM, Darbar D, Dell'Orto S, Roden DM. Exaggerated QT prolongation after
4981 cardioversion of atrial fibrillation. *J Am Coll Cardiol* 1999;**34**:396-401.
- 4982 672. Patten M, Maas R, Bauer P, Luderitz B, Sonntag F, Dluzniewski M, Hatala R, Opolski G,
4983 Muller HW, Meinertz T. Suppression of paroxysmal atrial tachyarrhythmias--results of the SOPAT trial.
4984 *Eur Heart J* 2004;**25**:1395-1404.
- 4985 673. Burashnikov A, Barajas-Martinez H, Hu D, Nof E, Blazek J, Antzelevitch C. Atrial-selective
4986 prolongation of refractory period with AVE0118 is due principally to inhibition of sodium channel
4987 activity. *J Cardiovasc Pharmacol* 2012;**59**:539-546.
- 4988 674. Ford J, Milnes J, Wettwer E, Christ T, Rogers M, Sutton K, Madge D, Virag L, Jost N, Horvath
4989 Z, Matschke K, Varro A, Ravens U. Human electrophysiological and pharmacological properties of
4990 XEN-D0101: a novel atrial-selective Kv1.5/IKur inhibitor. *J Cardiovasc Pharmacol* 2013;**61**:408-415.
- 4991 675. Loose S, Mueller J, Wettwer E, Knaut M, Ford J, Milnes J, Ravens U. Effects of IKur blocker
4992 MK-0448 on human right atrial action potentials from patients in sinus rhythm and in permanent atrial
4993 fibrillation. *Front Pharmacol* 2014;**5**:26.
- 4994 676. Schram G, Zhang L, Derakhchan K, Ehrlich JR, Belardinelli L, Nattel S. Ranolazine: ion-
4995 channel-blocking actions and in vivo electrophysiological effects. *Br J Pharmacol* 2004;**142**:1300-
4996 1308.
- 4997 677. McCormack JG, Barr RL, Wolff AA, Lopaschuk GD. Ranolazine stimulates glucose oxidation
4998 in normoxic, ischemic, and reperfused ischemic rat hearts. *Circulation* 1996;**93**:135-142.
- 4999 678. Scirica BM, Morrow DA, Hod H, Murphy SA, Belardinelli L, Hedgepeth CM, Molhoek P,
5000 Verheugt FW, Gersh BJ, McCabe CH, Braunwald E. Effect of ranolazine, an antianginal agent with
5001 novel electrophysiological properties, on the incidence of arrhythmias in patients with non ST-
5002 segment elevation acute coronary syndrome: results from the Metabolic Efficiency With Ranolazine
5003 for Less Ischemia in Non ST-Elevation Acute Coronary Syndrome Thrombolysis in Myocardial
5004 Infarction 36 (MERLIN-TIMI 36) randomized controlled trial. *Circulation* 2007;**116**:1647-1652.
- 5005 679. Scirica BM, Belardinelli L, Chaitman BR, Waks JW, Volo S, Karwadowska-Prokopczuk E,
5006 Murphy SA, Cheng ML, Braunwald E, Morrow DA. Effect of ranolazine on atrial fibrillation in patients
5007 with non-ST elevation acute coronary syndromes: observations from the MERLIN-TIMI 36 trial.
5008 *Europace* 2015;**17**:32-37.
- 5009 680. Reiffel JA, Camm AJ, Belardinelli L, Zeng D, Karwadowska-Prokopczuk E, Olmsted A, Zareba
5010 W, Rosero S, Kowey P, HARMONY Investigators. The HARMONY Trial: Combined Ranolazine and
5011 Dronedarone in the Management of Paroxysmal Atrial Fibrillation: Mechanistic and Therapeutic
5012 Synergism. *Circ Arrhythm Electrophysiol* 2015;**8**:1048-1056.
- 5013 681. Fragakis N, Koskinas KC, Katritsis DG, Pagourelis ED, Zografos T, Geleris P. Comparison
5014 of effectiveness of ranolazine plus amiodarone versus amiodarone alone for conversion of recent-
5015 onset atrial fibrillation. *Am J Cardiol* 2012;**110**:673-677.
- 5016 682. Simopoulos V, Tagarakis GI, Daskalopoulou SS, Daskalopoulos ME, Lenos A, Chryssagis K,
5017 Skoularingis I, Molyvdas PA, Tsilimingas NB, Aidonidis I. Ranolazine enhances the antiarrhythmic
5018 activity of amiodarone by accelerating conversion of new-onset atrial fibrillation after cardiac surgery.
5019 *Angiology* 2014;**65**:294-297.
- 5020 683. Koskinas KC, Fragakis N, Katritsis D, Skeberis V, Vassilikos V. Ranolazine enhances the
5021 efficacy of amiodarone for conversion of recent-onset atrial fibrillation. *Europace* 2014;**16**:973-979.
- 5022 684. De Ferrari GM, Maier LS, Mont L, Schwartz PJ, Simonis G, Leschke M, Gronda E, Boriani G,
5023 Darius H, Guillaumon Toran L, Savelieva I, Dusi V, Marchionni N, Quintana Rendon M, Schumacher K,
5024 Tonini G, Melani L, Giannelli S, Alberto Maggi C, Camm AJ, RAFFAELLO Investigators. Ranolazine in
5025 the treatment of atrial fibrillation: Results of the dose-ranging RAFFAELLO (Ranolazine in Atrial
5026 Fibrillation Following An Electrical Cardioversion) study. *Heart Rhythm* 2015;**12**:872-878.
- 5027 685. Martin RI, Pogoryelova O, Koref MS, Bourke JP, Teare MD, Keavney BD. Atrial fibrillation
5028 associated with ivabradine treatment: meta-analysis of randomised controlled trials. *Heart*
5029 2014;**100**:1506-1510.
- 5030 686. Okin PM, Wachtell K, Devereux RB, Harris KE, Jern S, Kjeldsen SE, Julius S, Lindholm LH,
5031 Nieminen MS, Edelman JM, Hille DA, Dahlof B. Regression of electrocardiographic left ventricular
5032 hypertrophy and decreased incidence of new-onset atrial fibrillation in patients with hypertension.
5033 *JAMA* 2006;**296**:1242-1248.

- 5034 687. Savelieva I, Kakouros N, Kourliouros A, Camm AJ. Upstream therapies for management of
5035 atrial fibrillation: review of clinical evidence and implications for European Society of Cardiology
5036 guidelines. Part II: secondary prevention. *Europace* 2011;**13**:610-625.
- 5037 688. Kuhlkamp V, Schirdewan A, Stangl K, Homberg M, Ploch M, Beck OA. Use of metoprolol
5038 CR/XL to maintain sinus rhythm after conversion from persistent atrial fibrillation: a randomized,
5039 double-blind, placebo-controlled study. *J Am Coll Cardiol* 2000;**36**:139-146.
- 5040 689. Liakopoulos OJ, Kuhn EW, Slottosch I, Wassmer G, Wahlers T. Preoperative statin therapy
5041 for patients undergoing cardiac surgery. *Cochrane Database Syst Rev* 2012;**4**:Cd008493.
- 5042 690. Kuhn EW, Liakopoulos OJ, Stange S, Deppe AC, Slottosch I, Choi YH, Wahlers T.
5043 Preoperative statin therapy in cardiac surgery: a meta-analysis of 90,000 patients. *Eur J Cardiothorac*
5044 *Surg* 2014;**45**:17-26; discussion 26.
- 5045 691. Zheng Z, Jayaram R, Jiang L, Emberson J, Zhao Y, Li Q, Du J, Guarguagli S, Hill M, Chen Z,
5046 Collins R, Casadei B. Perioperative Rosuvastatin in Cardiac Surgery. *N Engl J Med* 2016;**374**:1744-
5047 1753.
- 5048 692. Rahimi K, Emberson J, McGale P, Majoni W, Merhi A, Asselbergs FW, Krane V, Macfarlane
5049 PW, PROSPER Executive. Effect of statins on atrial fibrillation: collaborative meta-analysis of
5050 published and unpublished evidence from randomised controlled trials. *BMJ* 2011;**342**:d1250.
- 5051 693. Pinho-Gomes AC, Reilly S, Brandes RP, Casadei B. Targeting inflammation and oxidative
5052 stress in atrial fibrillation: role of 3-hydroxy-3-methylglutaryl-coenzyme a reductase inhibition with
5053 statins. *Antioxid Redox Signal* 2014;**20**:1268-1285.
- 5054 694. Bianconi L, Calo L, Mennuni M, Santini L, Morosetti P, Azzolini P, Barbato G, Biscione F,
5055 Romano P, Santini M. n-3 polyunsaturated fatty acids for the prevention of arrhythmia recurrence
5056 after electrical cardioversion of chronic persistent atrial fibrillation: a randomized, double-blind,
5057 multicentre study. *Europace* 2011;**13**:174-181.
- 5058 695. Kowey PR, Reiffel JA, Ellenbogen KA, Naccarelli GV, Pratt CM. Efficacy and safety of
5059 prescription omega-3 fatty acids for the prevention of recurrent symptomatic atrial fibrillation: a
5060 randomized controlled trial. *JAMA* 2010;**304**:2363-2372.
- 5061 696. Mozaffarian D, Marchioli R, Macchia A, Silletta MG, Ferrazzi P, Gardner TJ, Latini R, Libby P,
5062 Lombardi F, O'Gara PT, Page RL, Tavazzi L, Tognoni G, OPERA Investigators. Fish oil and
5063 postoperative atrial fibrillation: the Omega-3 Fatty Acids for Prevention of Post-operative Atrial
5064 Fibrillation (OPERA) randomized trial. *JAMA* 2012;**308**:2001-2011.
- 5065 697. Yamashita T, Inoue H, Okumura K, Kodama I, Aizawa Y, Atarashi H, Ohe T, Ohtsu H, Kato T,
5066 Kamakura S, Kumagai K, Kurachi Y, Koretsune Y, Saikawa T, Sakurai M, Sato T, Sugi K, Nakaya H,
5067 Hirai M, Hirayama A, Fukatani M, Mitamura H, Yamazaki T, Watanabe E, Ogawa S, J-RHYTHM II
5068 Investigators. Randomized trial of angiotensin II-receptor blocker vs. dihydropyridine calcium channel
5069 blocker in the treatment of paroxysmal atrial fibrillation with hypertension (J-RHYTHM II study).
5070 *Europace* 2011;**13**:473-479.
- 5071 698. Macchia A, Grancelli H, Varini S, Nul D, Laffaye N, Mariani J, Ferrante D, Badra R, Figal J,
5072 Ramos S, Tognoni G, Doval HC, GESICA Investigators. Omega-3 fatty acids for the prevention of
5073 recurrent symptomatic atrial fibrillation: results of the FORWARD (Randomized Trial to Assess
5074 Efficacy of PUFA for the Maintenance of Sinus Rhythm in Persistent Atrial Fibrillation) trial. *J Am Coll*
5075 *Cardiol* 2013;**61**:463-468.
- 5076 699. Dabrowski R, Borowiec A, Smolis-Bak E, Kowalik I, Sosnowski C, Kraska A, Kazimierska B,
5077 Wozniak J, Zareba W, Szwed H. Effect of combined spironolactone- β -blocker \pm enalapril treatment on
5078 occurrence of symptomatic atrial fibrillation episodes in patients with a history of paroxysmal atrial
5079 fibrillation (SPIR-AF study). *Am J Cardiol* 2010;**106**:1609-1614.
- 5080 700. Ito Y, Yamasaki H, Naruse Y, Yoshida K, Kaneshiro T, Murakoshi N, Igarashi M, Kuroki K,
5081 Machino T, Xu D, Kunugita F, Sekiguchi Y, Sato A, Tada H, Aonuma K. Effect of eplerenone on
5082 maintenance of sinus rhythm after catheter ablation in patients with long-standing persistent atrial
5083 fibrillation. *Am J Cardiol* 2013;**111**:1012-1018.
- 5084 701. Swedberg K, Zannad F, McMurray JJ, Krum H, van Veldhuisen DJ, Shi H, Vincent J, Pitt B,
5085 EMPHASIS-Hf Study Investigators. Eplerenone and atrial fibrillation in mild systolic heart failure:
5086 results from the EMPHASIS-HF (Eplerenone in Mild Patients Hospitalization And Survival Study in
5087 Heart Failure) study. *J Am Coll Cardiol* 2012;**59**:1598-1603.
- 5088 702. Coll-Vinent B, Sala X, Fernandez C, Bragulat E, Espinosa G, Miro O, Milla J, Sanchez M.
5089 Sedation for cardioversion in the emergency department: analysis of effectiveness in four protocols.
5090 *Ann Emerg Med* 2003;**42**:767-772.
- 5091 703. del Arco C, Martin A, Laguna P, Gargantilla P. Analysis of current management of atrial
5092 fibrillation in the acute setting: GEFAUR-1 study. *Ann Emerg Med* 2005;**46**:424-430.

- 5093 704. Scheuermeyer FX, Grafstein E, Heilbron B, Innes G. Emergency department management
5094 and 1-year outcomes of patients with atrial flutter. *Ann Emerg Med* 2011;**57**:564-571 e562.
- 5095 705. Goldner BG, Baker J, Accordino A, Sabatino L, DiGiulio M, Kalenderian D, Lin D, Zambrotta
5096 V, Stechel J, Maccaro P, Jadonath R. Electrical cardioversion of atrial fibrillation or flutter with
5097 conscious sedation in the age of cost containment. *Am Heart J* 1998;**136**:961-964.
- 5098 706. Martinez-Marcos FJ, Garcia-Garmendia JL, Ortega-Carpio A, Fernandez-Gomez JM, Santos
5099 JM, Camacho C. Comparison of intravenous flecainide, propafenone, and amiodarone for conversion
5100 of acute atrial fibrillation to sinus rhythm. *Am J Cardiol* 2000;**86**:950-953.
- 5101 707. Buccelletti F, Iacomini P, Botta G, Marsiliani D, Carroccia A, Gentiloni Silveri N, Franceschi F.
5102 Efficacy and safety of vernakalant in recent-onset atrial fibrillation after the European medicines
5103 agency approval: systematic review and meta-analysis. *J Clin Pharmacol* 2012;**52**:1872-1878.
- 5104 708. Cappato R, Ezekowitz MD, Klein AL, Camm AJ, Ma CS, Le Heuzey JY, Talajic M,
5105 Scanavacca M, Vardas PE, Kirchhof P, Hemmrich M, Lanius V, Meng IL, Wildgoose P, van Eickels M,
5106 Hohnloser SH, X-VerT Investigators. Rivaroxaban vs. vitamin K antagonists for cardioversion in atrial
5107 fibrillation. *Eur Heart J* 2014.
- 5108 709. Nagarakanti R, Ezekowitz MD, Oldgren J, Yang S, Chernick M, Aikens TH, Flaker G, Brugada
5109 J, Kamensky G, Parekh A, Reilly PA, Yusuf S, Connolly SJ. Dabigatran versus warfarin in patients
5110 with atrial fibrillation: an analysis of patients undergoing cardioversion. *Circulation* 2011;**123**:131-136.
- 5111 710. Steinberg JS, Sadaniantz A, Kron J, Krahn A, Denny DM, Daubert J, Campbell WB, Havranek
5112 E, Murray K, Olshansky B, O'Neill G, Sami M, Schmidt S, Storm R, Zabalgoitia M, Miller J, Chandler
5113 M, Nasco EM, Greene HL. Analysis of cause-specific mortality in the Atrial Fibrillation Follow-up
5114 Investigation of Rhythm Management (AFFIRM) study. *Circulation* 2004;**109**:1973-1980.
- 5115 711. Andersen HR, Nielsen JC, Thomsen PE, Thuesen L, Mortensen PT, Vesterlund T, Pedersen
5116 AK. Long-term follow-up of patients from a randomised trial of atrial versus ventricular pacing for sick-
5117 sinus syndrome. *Lancet* 1997;**350**:1210-1216.
- 5118 712. Connolly SJ, Kerr CR, Gent M, Roberts RS, Yusuf S, Gillis AM, Sami MH, Talajic M, Tang
5119 AS, Klein GJ, Lau C, Newman DM. Effects of physiologic pacing versus ventricular pacing on the risk
5120 of stroke and death due to cardiovascular causes. Canadian Trial of Physiologic Pacing Investigators.
5121 *N Engl J Med* 2000;**342**:1385-1391.
- 5122 713. Calkins H, Reynolds MR, Spector P, Sondhi M, Xu Y, Martin A, Williams CJ, Sledge I.
5123 Treatment of atrial fibrillation with antiarrhythmic drugs or radiofrequency ablation: two systematic
5124 literature reviews and meta-analyses. *Circ Arrhythm Electrophysiol* 2009;**2**:349-361.
- 5125 714. Schmieder RE, Kjeldsen SE, Julius S, McInnes GT, Zanchetti A, Hua TA. Reduced incidence
5126 of new-onset atrial fibrillation with angiotensin II receptor blockade: the VALUE trial. *J Hypertens*
5127 2008;**26**:403-411.
- 5128 715. Calkins H, Kuck KH, Cappato R, Brugada J, Camm AJ, Chen SA, Crijns HJ, Damiano RJ, Jr.,
5129 Davies DW, DiMarco J, Edgerton J, Ellenbogen K, Ezekowitz MD, Haines DE, Haissaguerre M,
5130 Hindricks G, Iesaka Y, Jackman W, Jalife J, Jais P, Kalman J, Keane D, Kim YH, Kirchhof P, Klein G,
5131 Kottkamp H, Kumagai K, Lindsay BD, Mansour M, Marchlinski FE, McCarthy PM, Mont JL, Morady F,
5132 Nademanee K, Nakagawa H, Natale A, Nattel S, Packer DL, Pappone C, Prystowsky E, Raviele A,
5133 Reddy V, Ruskin JN, Shemin RJ, Tsao HM, Wilber D. 2012 HRS/EHRA/ECAS Expert Consensus
5134 Statement on Catheter and Surgical Ablation of Atrial Fibrillation: recommendations for patient
5135 selection, procedural techniques, patient management and follow-up, definitions, endpoints, and
5136 research trial design. *Europace* 2012;**14**:528-606.
- 5137 716. Kuck KH, Hoffmann BA, Ernst S, Wegscheider K, Treszl A, Metzner A, Eckardt L, Lewalter T,
5138 Breithardt G, Willems S, Gap-AF–AFNET 1 Investigators. Impact of Complete Versus Incomplete
5139 Circumferential Lines Around the Pulmonary Veins During Catheter Ablation of Paroxysmal Atrial
5140 Fibrillation: Results From the Gap-Atrial Fibrillation-German Atrial Fibrillation Competence Network 1
5141 Trial. *Circ Arrhythm Electrophysiol* 2016;**9**:e003337.
- 5142 717. Mont L, Bisbal F, Hernandez-Madrid A, Perez-Castellano N, Vinolas X, Arenal A, Arribas F,
5143 Fernandez-Lozano I, Bodegas A, Cobos A, Matia R, Perez-Villacastin J, Guerra JM, Avila P, Lopez-
5144 Gil M, Castro V, Arana JI, Brugada J, SARA investigators. Catheter ablation vs. antiarrhythmic drug
5145 treatment of persistent atrial fibrillation: a multicentre, randomized, controlled trial (SARA study). *Eur*
5146 *Heart J* 2014;**35**:501-507.
- 5147 718. Schreiber D, Rostock T, Frohlich M, Sultan A, Servatius H, Hoffmann BA, Luker J, Berner I,
5148 Schaffer B, Wegscheider K, Lezius S, Willems S, Steven D. Five-year follow-up after catheter ablation
5149 of persistent atrial fibrillation using the stepwise approach and prognostic factors for success. *Circ*
5150 *Arrhythm Electrophysiol* 2015;**8**:308-317.
- 5151 719. Scherr D, Khairy P, Miyazaki S, Aurillac-Lavignolle V, Pascale P, Wilton SB, Ramoul K,
5152 Komatsu Y, Roten L, Jadidi A, Linton N, Pedersen M, Daly M, O'Neill M, Knecht S, Weerasooriya R,

- 5153 Rostock T, Manninger M, Cochet H, Shah AJ, Yeim S, Denis A, Derval N, Hocini M, Sacher F,
5154 Haissaguerre M, Jais P. Five-year outcome of catheter ablation of persistent atrial fibrillation using
5155 termination of atrial fibrillation as a procedural endpoint. *Circ Arrhythm Electrophysiol* 2015;**8**:18-24.
5156 720. Al Halabi S, Qintar M, Hussein A, Alraies MC, Jones DG, Wong T, MacDonald MR, Petrie
5157 MC, Cantillon D, Tarakji KG, Kanj M, Bhargava M, Varma N, Baranowski B, Wilkoff BL, Wazni O,
5158 Callahan T, Saliba W, Chung MK. Catheter Ablation for Atrial Fibrillation in Heart Failure Patients: A
5159 Meta-Analysis of Randomized Controlled Trials. *JACC Clin Electrophysiol* 2015;**1**:200-209.
5160 721. Hakalahti A, Biancari F, Nielsen JC, Raatikainen MJ. Radiofrequency ablation vs.
5161 antiarrhythmic drug therapy as first line treatment of symptomatic atrial fibrillation: systematic review
5162 and meta-analysis. *Europace* 2015;**17**:370-378.
5163 722. Morillo CA, Verma A, Connolly SJ, Kuck KH, Nair GM, Champagne J, Sterns LD, Beresh H,
5164 Healey JS, Natale A, RAAFT-2 Investigators. Radiofrequency ablation vs antiarrhythmic drugs as first-
5165 line treatment of paroxysmal atrial fibrillation (RAAFT-2): a randomized trial. *JAMA* 2014;**311**:692-700.
5166 723. Wazni OM, Marrouche NF, Martin DO, Verma A, Bhargava M, Saliba W, Bash D, Schweikert
5167 R, Brachmann J, Gunther J, Gutleben K, Pisano E, Potenza D, Fanelli R, Raviele A, Themistoclakis
5168 S, Rossillo A, Bonso A, Natale A. Radiofrequency ablation vs antiarrhythmic drugs as first-line
5169 treatment of symptomatic atrial fibrillation: a randomized trial. *JAMA* 2005;**293**:2634-2640.
5170 724. Oral H, Pappone C, Chugh A, Good E, Bogun F, Pelosi F, Jr., Bates ER, Lehmann MH,
5171 Vicedomini G, Augello G, Agricola E, Sala S, Santinelli V, Morady F. Circumferential pulmonary-vein
5172 ablation for chronic atrial fibrillation. *N Engl J Med* 2006;**354**:934-941.
5173 725. Stabile G, Bertaglia E, Senatore G, De Simone A, Zoppo F, Donnici G, Turco P, Pascotto P,
5174 Fazzari M, Vitale DF. Catheter ablation treatment in patients with drug-refractory atrial fibrillation: a
5175 prospective, multi-centre, randomized, controlled study (Catheter Ablation For The Cure Of Atrial
5176 Fibrillation Study). *Eur Heart J* 2006;**27**:216-221.
5177 726. Forleo GB, Mantica M, De Luca L, Leo R, Santini L, Panigada S, De Sanctis V, Pappalardo A,
5178 Laurenzi F, Avella A, Casella M, Dello Russo A, Romeo F, Pelargonio G, Tondo C. Catheter ablation
5179 of atrial fibrillation in patients with diabetes mellitus type 2: results from a randomized study
5180 comparing pulmonary vein isolation versus antiarrhythmic drug therapy. *J Cardiovasc Electrophysiol*
5181 2009;**20**:22-28.
5182 727. Cappato R, Calkins H, Chen SA, Davies W, Iesaka Y, Kalman J, Kim YH, Klein G, Natale A,
5183 Packer D, Skanes A, Ambrogi F, Biganzoli E. Updated worldwide survey on the methods, efficacy,
5184 and safety of catheter ablation for human atrial fibrillation. *Circ Arrhythm Electrophysiol* 2010;**3**:32-38.
5185 728. Ganesan AN, Shipp NJ, Brooks AG, Kuklik P, Lau DH, Lim HS, Sullivan T, Roberts-Thomson
5186 KC, Sanders P. Long-term outcomes of catheter ablation of atrial fibrillation: a systematic review and
5187 meta-analysis. *J Am Heart Assoc* 2013;**2**:e004549.
5188 729. McLellan AJ, Ling LH, Azzopardi S, Lee GA, Lee G, Kumar S, Wong MC, Walters TE, Lee
5189 JM, Looi KL, Halloran K, Stiles MK, Lever NA, Fynn SP, Heck PM, Sanders P, Morton JB, Kalman
5190 JM, Kistler PM. A minimal or maximal ablation strategy to achieve pulmonary vein isolation for
5191 paroxysmal atrial fibrillation: a prospective multi-centre randomized controlled trial (the Minimax
5192 study). *Eur Heart J* 2015;**36**:1812-1821.
5193 730. Verma A, Sanders P, Macle L, Deisenhofer I, Morillo CA, Chen J, Jiang CY, Ernst S,
5194 Mantovan R. Substrate and Trigger Ablation for Reduction of Atrial Fibrillation Trial-Part II (STAR AF
5195 II): design and rationale. *Am Heart J* 2012;**164**:1-6 e6.
5196 731. Nery PB, Belliveau D, Nair GM, Bernick J, Redpath CJ, Szczotka A, Sadek MM, Green MS,
5197 Wells G, Birnie DH. Relationship Between Pulmonary Vein Reconnection and
5198 Atrial Fibrillation Recurrence. *JACC Clin Electrophysiol* 2016:[Epub ahead of print].
5199 732. Luik A, Radzewitz A, Kieser M, Walter M, Bramlage P, Hormann P, Schmidt K, Horn N,
5200 Brinkmeier-Theofanopoulou M, Kunzmann K, Riexinger T, Schymik G, Merkel M, Schmitt C.
5201 Cryoballoon Versus Open Irrigated Radiofrequency Ablation in Patients With Paroxysmal Atrial
5202 Fibrillation: The Prospective, Randomized, Controlled, Noninferiority FreezeAF Study. *Circulation*
5203 2015;**132**:1311-1319.
5204 733. Schmidt M, Dorwarth U, Andresen D, Brachmann J, Kuck KH, Kuniss M, Lewalter T, Spitzer
5205 S, Willems S, Senges J, Junger C, Hoffmann E. Cryoballoon versus RF ablation in paroxysmal atrial
5206 fibrillation: results from the German Ablation Registry. *J Cardiovasc Electrophysiol* 2014;**25**:1-7.
5207 734. Kuck KH, Brugada J, Furnkranz A, Metzner A, Ouyang F, Chun KR, Elvan A, Arentz T,
5208 Bestehorn K, Pocock SJ, Albenque JP, Tondo C, FIRE AND ICE Investigators. Cryoballoon or
5209 Radiofrequency Ablation for Paroxysmal Atrial Fibrillation. *N Engl J Med* 2016:[Epub ahead of print].
5210 735. Verma A, Jiang CY, Betts TR, Chen J, Deisenhofer I, Mantovan R, Macle L, Morillo CA,
5211 Haverkamp W, Weerasooriya R, Albenque JP, Nardi S, Menardi E, Novak P, Sanders P, STAR AF II

- 5212 Investigators. Approaches to catheter ablation for persistent atrial fibrillation. *N Engl J Med*
5213 2015;**372**:1812-1822.
- 5214 736. Dong JZ, Sang CH, Yu RH, Long DY, Tang RB, Jiang CX, Ning M, Liu N, Liu XP, Du X, Tse
5215 HF, Ma CS. Prospective randomized comparison between a fixed '2C3L' approach vs. stepwise
5216 approach for catheter ablation of persistent atrial fibrillation. *Europace* 2015;**17**:1798-1806.
- 5217 737. Hunter RJ, McCreedy J, Diab I, Page SP, Finlay M, Richmond L, French A, Earley MJ,
5218 Sporton S, Jones M, Joseph JP, Bashir Y, Betts TR, Thomas G, Staniforth A, Lee G, Kistler P,
5219 Rajappan K, Chow A, Schilling RJ. Maintenance of sinus rhythm with an ablation strategy in patients
5220 with atrial fibrillation is associated with a lower risk of stroke and death. *Heart* 2012;**98**:48-53.
- 5221 738. Providencia R, Lambiase PD, Srinivasan N, Ganesh Babu G, Bronis K, Ahsan S, Khan FZ,
5222 Chow AW, Rowland E, Lowe M, Segal OR. Is There Still a Role for Complex Fractionated Atrial
5223 Electrogram Ablation in Addition to Pulmonary Vein Isolation in Patients With Paroxysmal and
5224 Persistent Atrial Fibrillation? Meta-Analysis of 1415 Patients. *Circ Arrhythm Electrophysiol*
5225 2015;**8**:1017-1029.
- 5226 739. Mohanty S, Gianni C, Mohanty P, Halbfass P, Metz T, Trivedi C, Deneke T, Tomassoni G, Bai
5227 R, Al-Ahmad A, Bailey S, Burkhardt JD, Gallingshouse GJ, Horton R, Hranitzky PM, Sanchez JE, Di
5228 Biase L, Natale A. Impact of Rotor Ablation in Non-Paroxysmal AF Patients: Results from a
5229 Randomized Trial (OASIS). *J Am Coll Cardiol* 2016.
- 5230 740. Rolf S, Kircher S, Arya A, Eitel C, Sommer P, Richter S, Gaspar T, Bollmann A, Altmann D,
5231 Piedra C, Hindricks G, Piorkowski C. Tailored atrial substrate modification based on low-voltage areas
5232 in catheter ablation of atrial fibrillation. *Circ Arrhythm Electrophysiol* 2014;**7**:825-833.
- 5233 741. Shah AJ, Pascale P, Miyazaki S, Liu X, Roten L, Derval N, Jadidi AS, Scherr D, Wilton SB,
5234 Pedersen M, Knecht S, Sacher F, Jais P, Haissaguerre M, Hocini M. Prevalence and types of pitfall in
5235 the assessment of mitral isthmus linear conduction block. *Circ Arrhythm Electrophysiol* 2012;**5**:957-
5236 967.
- 5237 742. Macle L, Khairy P, Weerasooriya R, Novak P, Verma A, Willems S, Arentz T, Deisenhofer I,
5238 Veenhuyzen G, Scavee C, Jais P, Puererfellner H, Levesque S, Andrade JG, Rivard L, Guerra PG,
5239 Dubuc M, Thibault B, Talajic M, Roy D, Nattel S, ADVICE trial investigators. Adenosine-guided
5240 pulmonary vein isolation for the treatment of paroxysmal atrial fibrillation: an international, multicentre,
5241 randomised superiority trial. *Lancet* 2015;**386**:672-679.
- 5242 743. Kobori A, Shizuta S, Inoue K, Kaitani K, Morimoto T, Nakazawa Y, Ozawa T, Kurotobi T,
5243 Morishima I, Miura F, Watanabe T, Masuda M, Naito M, Fujimoto H, Nishida T, Furukawa Y,
5244 Shirayama T, Tanaka M, Okajima K, Yao T, Egami Y, Satomi K, Noda T, Miyamoto K, Haruna T,
5245 Kawaji T, Yoshizawa T, Toyota T, Yahata M, Nakai K, Sugiyama H, Higashi Y, Ito M, Horie M, Kusano
5246 KF, Shimizu W, Kamakura S, Kimura T, UNDER-ATP Trial Investigators. Adenosine triphosphate-
5247 guided pulmonary vein isolation for atrial fibrillation: the UNmasking Dormant Electrical Reconnection
5248 by Adenosine TriPhosphate (UNDER-ATP) trial. *Eur Heart J* 2015;**36**:3276-3287.
- 5249 744. Berntsen RF, Haland TF, Skardal R, Holm T. Focal impulse and rotor modulation as a stand-
5250 alone procedure for treatment of paroxysmal atrial fibrillation. A within-patient controlled study with
5251 implanted cardiac monitoring. *Heart Rhythm* 2016.
- 5252 745. Lee G, Sparks PB, Morton JB, Kistler PM, Vohra JK, Medi C, Rosso R, Teh A, Halloran K,
5253 Kalman JM. Low risk of major complications associated with pulmonary vein antral isolation for atrial
5254 fibrillation: results of 500 consecutive ablation procedures in patients with low prevalence of structural
5255 heart disease from a single center. *J Cardiovasc Electrophysiol* 2011;**22**:163-168.
- 5256 746. Wynn GJ, Das M, Bonnett LJ, Panikker S, Wong T, Gupta D. Efficacy of catheter ablation for
5257 persistent atrial fibrillation: a systematic review and meta-analysis of evidence from randomized and
5258 nonrandomized controlled trials. *Circ Arrhythm Electrophysiol* 2014;**7**:841-852.
- 5259 747. Seaburg L, Hess EP, Coylewright M, Ting HH, McLeod CJ, Montori VM. Shared decision
5260 making in atrial fibrillation: where we are and where we should be going. *Circulation* 2014;**129**:704-
5261 710.
- 5262 748. Dagres N, Hindricks G, Kottkamp H, Sommer P, Gaspar T, Bode K, Arya A, Husser D,
5263 Rallidis LS, Kremastinos DT, Piorkowski C. Complications of atrial fibrillation ablation in a high-volume
5264 center in 1,000 procedures: still cause for concern? *J Cardiovasc Electrophysiol* 2009;**20**:1014-1019.
- 5265 749. Deneke T, Jais P, Scaglione M, Schmitt R, L DIB, Christopoulos G, Schade A, Mugge A,
5266 Bansmann M, Nentwich K, Muller P, Roos M, Halbfass P, Natale A, Gaita F, Haines D. Silent
5267 cerebral events/lesions related to atrial fibrillation ablation: a clinical review. *J Cardiovasc*
5268 *Electrophysiol* 2015;**26**:455-463.
- 5269 750. Gupta A, Perera T, Ganesan A, Sullivan T, Lau DH, Roberts-Thomson KC, Brooks AG,
5270 Sanders P. Complications of catheter ablation of atrial fibrillation: a systematic review. *Circ Arrhythm*
5271 *Electrophysiol* 2013;**6**:1082-1088.

- 5272 751. Cappato R, Calkins H, Chen SA, Davies W, Iesaka Y, Kalman J, Kim YH, Klein G, Natale A,
5273 Packer D, Ricci C, Skanes A, Ranucci M. Delayed cardiac tamponade after radiofrequency catheter
5274 ablation of atrial fibrillation: a worldwide report. *J Am Coll Cardiol* 2011;**58**:2696-2697.
- 5275 752. Haeusler KG, Kirchhof P, Endres M. Left atrial catheter ablation and ischemic stroke. *Stroke*
5276 2012;**43**:265-270.
- 5277 753. Kosiuk J, Kornej J, Bollmann A, Piorkowski C, Myrda K, Arya A, Sommer P, Richter S, Rolf S,
5278 Husser D, Gaspar T, Lip GY, Hindricks G. Early cerebral thromboembolic complications after
5279 radiofrequency catheter ablation of atrial fibrillation: incidence, characteristics, and risk factors. *Heart*
5280 *Rhythm* 2014;**11**:1934-1940.
- 5281 754. Gaita F, Leclercq JF, Schumacher B, Scaglione M, Toso E, Halimi F, Schade A, Froehner S,
5282 Ziegler V, Sergi D, Cesarani F, Blandino A. Incidence of silent cerebral thromboembolic lesions after
5283 atrial fibrillation ablation may change according to technology used: comparison of irrigated
5284 radiofrequency, multipolar nonirrigated catheter and cryoballoon. *J Cardiovasc Electrophysiol*
5285 2011;**22**:961-968.
- 5286 755. Hsu LF, Jais P, Hocini M, Sanders P, Scavee C, Sacher F, Takahashi Y, Rotter M, Pasquie
5287 JL, Clementy J, Haissaguerre M. Incidence and prevention of cardiac tamponade complicating
5288 ablation for atrial fibrillation. *Pacing Clin Electrophysiol* 2005;**28 Suppl 1**:S106-109.
- 5289 756. Michowitz Y, Rahkovich M, Oral H, Zado ES, Tiltz R, John S, Denis A, Di Biase L, Winkle RA,
5290 Mikhaylov EN, Ruskin JN, Yao Y, Josephson ME, Tanner H, Miller JM, Champagne J, Della Bella P,
5291 Kumagai K, Defaye P, Luria D, Lebedev DS, Natale A, Jais P, Hindricks G, Kuck KH, Marchlinski FE,
5292 Morady F, Belhassen B. Effects of sex on the incidence of cardiac tamponade after catheter ablation
5293 of atrial fibrillation: results from a worldwide survey in 34 943 atrial fibrillation ablation procedures. *Circ*
5294 *Arrhythm Electrophysiol* 2014;**7**:274-280.
- 5295 757. Nair KK, Shurrab M, Skanes A, Danon A, Birnie D, Morillo C, Chauhan V, Mangat I, Ayala-
5296 Paredes F, Champagne J, Nault I, Tang A, Verma A, Lashevsky I, Singh SM, Crystal E. The
5297 prevalence and risk factors for atrioesophageal fistula after percutaneous radiofrequency catheter
5298 ablation for atrial fibrillation: the Canadian experience. *J Interv Card Electrophysiol* 2014;**39**:139-144.
- 5299 758. Shah RU, Freeman JV, Shilane D, Wang PJ, Go AS, Hlatky MA. Procedural complications,
5300 rehospitalizations, and repeat procedures after catheter ablation for atrial fibrillation. *J Am Coll Cardiol*
5301 2012;**59**:143-149.
- 5302 759. Straube F, Dorwarth U, Schmidt M, Wankel M, Ebersberger U, Hoffmann E. Comparison of
5303 the first and second cryoballoon: high-volume single-center safety and efficacy analysis. *Circ*
5304 *Arrhythm Electrophysiol* 2014;**7**:293-299.
- 5305 760. Di Biase L, Burkhardt JD, Santangeli P, Mohanty P, Sanchez JE, Horton R, Gallinghouse GJ,
5306 Themistoclakis S, Rossillo A, Lakkireddy D, Reddy M, Hao S, Hongo R, Beheiry S, Zagrodzky J,
5307 Rong B, Mohanty S, Elayi CS, Forleo G, Pelargonio G, Narducci ML, Dello Russo A, Casella M,
5308 Fassini G, Tondo C, Schweikert RA, Natale A. Periprocedural Stroke and Bleeding Complications in
5309 Patients Undergoing Catheter Ablation of Atrial Fibrillation With Different Anticoagulation
5310 Management: Results From the Role of Coumadin in Preventing Thromboembolism in Atrial
5311 Fibrillation (AF) Patients Undergoing Catheter Ablation (COMPARE) Randomized Trial. *Circulation*
5312 2014;**129**:2638-2644.
- 5313 761. Di Biase L, Lakkireddy D, Trivedi C, Deneke T, Martinek M, Mohanty S, Mohanty P, Prakash
5314 S, Bai R, Reddy M, Gianni C, Horton R, Bailey S, Sigmund E, Derndorfer M, Schade A, Mueller P,
5315 Szoelloes A, Sanchez J, Al-Ahmad A, Hranitzky P, Gallinghouse GJ, Hongo RH, Beheiry S,
5316 Purefellner H, Burkhardt JD, Natale A. Feasibility and safety of uninterrupted periprocedural
5317 apixaban administration in patients undergoing radiofrequency catheter ablation for atrial fibrillation:
5318 Results from a multicenter study. *Heart Rhythm* 2015;**12**:1162-1168.
- 5319 762. Hohnloser SH, Camm AJ. Safety and efficacy of dabigatran etexilate during catheter ablation
5320 of atrial fibrillation: a meta-analysis of the literature. *Europace* 2013;**15**:1407-1411.
- 5321 763. Lakkireddy D, Reddy YM, Di Biase L, Vallakati A, Mansour MC, Santangeli P, Gangireddy S,
5322 Swarup V, Chalhoub F, Atkins D, Bommana S, Verma A, Sanchez JE, Burkhardt JD, Barrett CD,
5323 Baheiry S, Ruskin J, Reddy V, Natale A. Feasibility and safety of uninterrupted rivaroxaban for
5324 periprocedural anticoagulation in patients undergoing radiofrequency ablation for atrial fibrillation:
5325 results from a multicenter prospective registry. *J Am Coll Cardiol* 2014;**63**:982-988.
- 5326 764. Providencia R, Marijon E, Albenque JP, Combes S, Combes N, Jourda F, Hireche H, Morais
5327 J, Boveda S. Rivaroxaban and dabigatran in patients undergoing catheter ablation of atrial fibrillation.
5328 *Europace* 2014;**16**:1137-1144.
- 5329 765. Stepanyan G, Badhwar N, Lee RJ, Marcus GM, Lee BK, Tseng ZH, Vedantham V, Olgin J,
5330 Scheinman M, Gerstenfeld EP. Safety of new oral anticoagulants for patients undergoing atrial
5331 fibrillation ablation. *J Interv Card Electrophysiol* 2014;**40**:33-38.

- 5332 766. Aryal MR, Ukaigwe A, Pandit A, Karmacharya P, Pradhan R, Mainali NR, Pathak R, Jalota L,
5333 Bhandari Y, Donato A. Meta-analysis of efficacy and safety of rivaroxaban compared with warfarin or
5334 dabigatran in patients undergoing catheter ablation for atrial fibrillation. *Am J Cardiol* 2014;**114**:577-
5335 582.
- 5336 767. Kaess BM, Ammar S, Reents T, Dillier R, Lennerz C, Semmler V, Grebmer C, Bourier F,
5337 Buiatti A, Kolb C, Deisenhofer I, Hessling G. Comparison of safety of left atrial catheter ablation
5338 procedures for atrial arrhythmias under continuous anticoagulation with apixaban versus
5339 phenprocoumon. *Am J Cardiol* 2015;**115**:47-51.
- 5340 768. Cappato R, Marchlinski FE, Hohnloser SH, Naccarelli GV, Xiang J, Wilber DJ, Ma CS, Hess
5341 S, Wells DS, Juang G, Vijgen J, Hugl BJ, Balasubramaniam R, De Chillou C, Davies DW, Fields LE,
5342 Natale A, VENTURE-AF Investigators. Uninterrupted rivaroxaban vs. uninterrupted vitamin K
5343 antagonists for catheter ablation in non-valvular atrial fibrillation. *Eur Heart J* 2015;**36**:1805-1811.
- 5344 769. Wu S, Yang YM, Zhu J, Wan HB, Wang J, Zhang H, Shao XH. Meta-Analysis of Efficacy and
5345 Safety of New Oral Anticoagulants Compared With Uninterrupted Vitamin K Antagonists in Patients
5346 Undergoing Catheter Ablation for Atrial Fibrillation. *Am J Cardiol* 2016;**117**:926-934.
- 5347 770. Santarpia G, De Rosa S, Polimeni A, Giampa S, Micieli M, Curcio A, Indolfi C. Efficacy and
5348 Safety of Non-Vitamin K Antagonist Oral Anticoagulants versus Vitamin K Antagonist Oral
5349 Anticoagulants in Patients Undergoing Radiofrequency Catheter Ablation of Atrial Fibrillation: A Meta-
5350 Analysis. *PLoS One* 2015;**10**:e0126512.
- 5351 771. Karasoy D, Gislason GH, Hansen J, Johannessen A, Kober L, Hvidtfeldt M, Ozcan C, Torp-
5352 Pedersen C, Hansen ML. Oral anticoagulation therapy after radiofrequency ablation of atrial fibrillation
5353 and the risk of thromboembolism and serious bleeding: long-term follow-up in nationwide cohort of
5354 Denmark. *Eur Heart J* 2015;**36**:307-314a.
- 5355 772. Themistoclakis S, Corrado A, Marchlinski FE, Jais P, Zado E, Rossillo A, Di Biase L,
5356 Schweikert RA, Saliba WI, Horton R, Mohanty P, Patel D, Burkhardt DJ, Wazni OM, Bonso A, Callans
5357 DJ, Haissaguerre M, Raviele A, Natale A. The risk of thromboembolism and need for oral
5358 anticoagulation after successful atrial fibrillation ablation. *J Am Coll Cardiol* 2010;**55**:735-743.
- 5359 773. Bunch TJ, May HT, Bair TL, Weiss JP, Crandall BG, Osborn JS, Mallender C, Anderson JL,
5360 Muhlestein BJ, Lappe DL, Day JD. Atrial fibrillation ablation patients have long-term stroke rates
5361 similar to patients without atrial fibrillation regardless of CHADS2 score. *Heart Rhythm* 2013;**10**:1272-
5362 1277.
- 5363 774. Nedios S, Kornej J, Koutalas E, Bertagnoli L, Kosiuk J, Rolf S, Arya A, Sommer P, Husser D,
5364 Hindricks G, Bollmann A. Left atrial appendage morphology and thromboembolic risk after catheter
5365 ablation for atrial fibrillation. *Heart Rhythm* 2014;**11**:2239-2246.
- 5366 775. Reynolds MR, Gunnarsson CL, Hunter TD, Ladapo JA, March JL, Zhang M, Hao SC. Health
5367 outcomes with catheter ablation or antiarrhythmic drug therapy in atrial fibrillation: results of a
5368 propensity-matched analysis. *Circ Cardiovasc Qual Outcomes* 2012;**5**:171-181.
- 5369 776. Gallo C, Battaglia A, Anselmino M, Bianchi F, Grossi S, Nangeroni G, Toso E, Gaido L,
5370 Scaglione M, Ferraris F, Gaita F. Long-term events following atrial fibrillation rate control or
5371 transcatheter ablation: a multicenter observational study. *J Cardiovasc Med (Hagerstown)*
5372 2016;**17**:187-193.
- 5373 777. Di Biase L, Mohanty P, Mohanty S, Santangeli P, Trivedi C, Lakkireddy D, Reddy M, Jais P,
5374 Themistoclakis S, Dello Russo A, Casella M, Pelargonio G, Narducci ML, Schweikert R, Neuzil P,
5375 Sanchez J, Horton R, Beheiry S, Hongo R, Hao S, Rossillo A, Forleo G, Tondo C, Burkhardt JD,
5376 Haissaguerre M, Natale A. Ablation vs. Amiodarone for Treatment of Persistent Atrial Fibrillation in
5377 Patients With Congestive Heart Failure and an Implanted Device: Results From the AATAC
5378 Multicenter Randomized Trial. *Circulation* 2016.
- 5379 778. Hunter RJ, Berriman TJ, Diab I, Kamdar R, Richmond L, Baker V, Goromonzi F, Sawhney V,
5380 Duncan E, Page SP, Ullah W, Unsworth B, Mayet J, Dhinoja M, Earley MJ, Sporton S, Schilling RJ. A
5381 randomized controlled trial of catheter ablation versus medical treatment of atrial fibrillation in heart
5382 failure (the CAMTAF trial). *Circ Arrhythm Electrophysiol* 2014;**7**:31-38.
- 5383 779. MacDonald MR, Connelly DT, Hawkins NM, Steedman T, Payne J, Shaw M, Denvir M,
5384 Bhagra S, Small S, Martin W, McMurray JJ, Petrie MC. Radiofrequency ablation for persistent atrial
5385 fibrillation in patients with advanced heart failure and severe left ventricular systolic dysfunction: a
5386 randomised controlled trial. *Heart* 2011;**97**:740-747.
- 5387 780. Dagues N, Varounis C, Gaspar T, Piorkowski C, Eitel C, Iliodromitis EK, Lekakis JP, Flevari P,
5388 Simeonidou E, Rallidis LS, Tsougos E, Hindricks G, Sommer P, Anastasiou-Nana M. Catheter
5389 ablation for atrial fibrillation in patients with left ventricular systolic dysfunction. A systematic review
5390 and meta-analysis. *J Card Fail* 2011;**17**:964-970.

- 5391 781. Piorkowski C, Kottkamp H, Tanner H, Kobza R, Nielsen JC, Arya A, Hindricks G. Value of
5392 different follow-up strategies to assess the efficacy of circumferential pulmonary vein ablation for the
5393 curative treatment of atrial fibrillation. *J Cardiovasc Electrophysiol* 2005;**16**:1286-1292.
- 5394 782. Verma A, Champagne J, Sapp J, Essebag V, Novak P, Skanes A, Morillo CA, Khaykin Y,
5395 Birnie D. Discerning the incidence of symptomatic and asymptomatic episodes of atrial fibrillation
5396 before and after catheter ablation (DISCERN AF): a prospective, multicenter study. *JAMA Intern Med*
5397 2013;**173**:149-156.
- 5398 783. Cox JL, Boineau JP, Schuessler RB, Ferguson TB, Jr., Cain ME, Lindsay BD, Corr PB, Kater
5399 KM, Lappas DG. Successful surgical treatment of atrial fibrillation. Review and clinical update. *JAMA*
5400 1991;**266**:1976-1980.
- 5401 784. Cox JL, Schuessler RB, D'Agostino HJ, Jr., Stone CM, Chang BC, Cain ME, Corr PB,
5402 Boineau JP. The surgical treatment of atrial fibrillation. III. Development of a definitive surgical
5403 procedure. *J Thorac Cardiovasc Surg* 1991;**101**:569-583.
- 5404 785. Stulak JM, Suri RM, Burkhart HM, Daly RC, Dearani JA, Greason KL, Joyce LD, Park SJ,
5405 Schaff HV. Surgical ablation for atrial fibrillation for two decades: are the results of new techniques
5406 equivalent to the Cox maze III procedure? *J Thorac Cardiovasc Surg* 2014;**147**:1478-1486.
- 5407 786. Basu S, Nagendran M, Maruthappu M. How effective is bipolar radiofrequency ablation for
5408 atrial fibrillation during concomitant cardiac surgery? *Interact Cardiovasc Thorac Surg* 2012;**15**:741-
5409 748.
- 5410 787. Lin Z, Shan ZG, Liao CX, Chen LW. The effect of microwave and bipolar radio-frequency
5411 ablation in the surgical treatment of permanent atrial fibrillation during valve surgery. *Thorac*
5412 *Cardiovasc Surg* 2011;**59**:460-464.
- 5413 788. McCarthy PM, Kruse J, Shalji S, Ilkhanoff L, Goldberger JJ, Kadish AH, Arora R, Lee R.
5414 Where does atrial fibrillation surgery fail? Implications for increasing effectiveness of ablation. *J*
5415 *Thorac Cardiovasc Surg* 2010;**139**:860-867.
- 5416 789. Abreu Filho CA, Lisboa LA, Dallan LA, Spina GS, Grinberg M, Scanavacca M, Sosa EA,
5417 Ramires JA, Oliveira SA. Effectiveness of the maze procedure using cooled-tip radiofrequency
5418 ablation in patients with permanent atrial fibrillation and rheumatic mitral valve disease. *Circulation*
5419 2005;**112**:I20-25.
- 5420 790. Blomstrom-Lundqvist C, Johansson B, Berglin E, Nilsson L, Jensen SM, Thelin S, Holmgren
5421 A, Edvardsson N, Kallner G, Blomstrom P. A randomized double-blind study of epicardial left atrial
5422 cryoablation for permanent atrial fibrillation in patients undergoing mitral valve surgery: the SWEDish
5423 Multicentre Atrial Fibrillation study (SWEDMAF). *Eur Heart J* 2007;**28**:2902-2908.
- 5424 791. Chevalier P, Leizorovicz A, Maureira P, Cartheaux JP, Corbineau H, Caus T, DeBreyne B,
5425 Mabot P, Dechillou C, Deharo JC, Barry S, Touboul P, Villemot JP, Obadia JF. Left atrial
5426 radiofrequency ablation during mitral valve surgery: a prospective randomized multicentre study
5427 (SAFIR). *Arch Cardiovasc Dis* 2009;**102**:769-775.
- 5428 792. Deneke T, Khargi K, Grewe PH, Laczkovics A, von Dryander S, Lawo T, Muller KM, Lemke B.
5429 Efficacy of an additional MAZE procedure using cooled-tip radiofrequency ablation in patients with
5430 chronic atrial fibrillation and mitral valve disease. A randomized, prospective trial. *Eur Heart J*
5431 2002;**23**:558-566.
- 5432 793. Doukas G, Samani NJ, Alexiou C, Oc M, Chin DT, Stafford PG, Ng LL, Spyt TJ. Left atrial
5433 radiofrequency ablation during mitral valve surgery for continuous atrial fibrillation: a randomized
5434 controlled trial. *JAMA* 2005;**294**:2323-2329.
- 5435 794. Schuetz A, Schulze CJ, Sarvanakis KK, Mair H, Plazer H, Kilger E, Reichart B, Wildhirt SM.
5436 Surgical treatment of permanent atrial fibrillation using microwave energy ablation: a prospective
5437 randomized clinical trial. *Eur J Cardiothorac Surg* 2003;**24**:475-480; discussion 480.
- 5438 795. Liu X, Tan HW, Wang XH, Shi HF, Li YZ, Li F, Zhou L, Gu JN. Efficacy of catheter ablation
5439 and surgical CryoMaze procedure in patients with long-lasting persistent atrial fibrillation and
5440 rheumatic heart disease: a randomized trial. *Eur Heart J* 2010;**31**:2633-2641.
- 5441 796. Cheng DC, Ad N, Martin J, Berglin EE, Chang BC, Doukas G, Gammie JS, Nitta T, Wolf RK,
5442 Puskas JD. Surgical ablation for atrial fibrillation in cardiac surgery: a meta-analysis and systematic
5443 review. *Innovations (Phila)* 2010;**5**:84-96.
- 5444 797. Barnett SD, Ad N. Surgical ablation as treatment for the elimination of atrial fibrillation: a
5445 meta-analysis. *J Thorac Cardiovasc Surg* 2006;**131**:1029-1035.
- 5446 798. Ad N, Henry L, Massimiano P, Pritchard G, Holmes SD. The state of surgical ablation for
5447 atrial fibrillation in patients with mitral valve disease. *Curr Opin Cardiol* 2013;**28**:170-180.
- 5448 799. Gammie JS, Haddad M, Milford-Beland S, Welke KF, Ferguson TB, Jr., O'Brien SM, Griffith
5449 BP, Peterson ED. Atrial fibrillation correction surgery: lessons from the Society of Thoracic Surgeons
5450 National Cardiac Database. *Ann Thorac Surg* 2008;**85**:909-914.

- 5451 800. Chen MC, Chang JP, Chang HW. Preoperative atrial size predicts the success of
5452 radiofrequency maze procedure for permanent atrial fibrillation in patients undergoing concomitant
5453 valvular surgery. *Chest* 2004;**125**:2129-2134.
- 5454 801. Sunderland N, Maruthappu M, Nagendran M. What size of left atrium significantly impairs the
5455 success of maze surgery for atrial fibrillation? *Interact Cardiovasc Thorac Surg* 2011;**13**:332-338.
- 5456 802. Chaiyaraj S, Ngarmukos T, Lertsithichai P. Predictors of sinus rhythm after radiofrequency
5457 maze and mitral valve surgery. *Asian Cardiovasc Thorac Ann* 2008;**16**:292-297.
- 5458 803. Gillinov AM, Bhavani S, Blackstone EH, Rajeswaran J, Svensson LG, Navia JL, Pettersson
5459 BG, Sabik JF, 3rd, Smedira NG, Mihaljevic T, McCarthy PM, Shewchik J, Natale A. Surgery for
5460 permanent atrial fibrillation: impact of patient factors and lesion set. *Ann Thorac Surg* 2006;**82**:502-
5461 513; discussion 513-504.
- 5462 804. Beukema WP, Sie HT, Misier AR, Delnoy PP, Wellens HJ, Elvan A. Predictive factors of
5463 sustained sinus rhythm and recurrent atrial fibrillation after a radiofrequency modified Maze
5464 procedure. *Eur J Cardiothorac Surg* 2008;**34**:771-775.
- 5465 805. Gillinov AM, Bakaeen F, McCarthy PM, Blackstone EH, Rajeswaran J, Pettersson G, Sabik
5466 JF, 3rd, Najam F, Hill KM, Svensson LG, Cosgrove DM, Marrouche N, Natale A. Surgery for
5467 paroxysmal atrial fibrillation in the setting of mitral valve disease: a role for pulmonary vein isolation?
5468 *Ann Thorac Surg* 2006;**81**:19-26; discussion 27-18.
- 5469 806. Onorati F, Mariscalco G, Rubino AS, Serraino F, Santini F, Musazzi A, Klersy C, Sala A,
5470 Renzulli A. Impact of lesion sets on mid-term results of surgical ablation procedure for atrial fibrillation.
5471 *J Am Coll Cardiol* 2011;**57**:931-940.
- 5472 807. Saint LL, Bailey MS, Prasad S, Guthrie TJ, Bell J, Moon MR, Lawton JS, Munfakh NA,
5473 Schuessler RB, Damiano RJ, Jr., Maniar HS. Cox-Maze IV results for patients with lone atrial
5474 fibrillation versus concomitant mitral disease. *Ann Thorac Surg* 2012;**93**:789-794; discussion 794-785.
- 5475 808. Lawrance CP, Henn MC, Miller JR, Sinn LA, Schuessler RB, Maniar HS, Damiano RJ, Jr. A
5476 minimally invasive Cox maze IV procedure is as effective as sternotomy while decreasing major
5477 morbidity and hospital stay. *J Thorac Cardiovasc Surg* 2014;**148**:955-961; discussion 962-952.
- 5478 809. Edgerton JR, Brinkman WT, Weaver T, Prince SL, Culica D, Herbert MA, Mack MJ.
5479 Pulmonary vein isolation and autonomic denervation for the management of paroxysmal atrial
5480 fibrillation by a minimally invasive surgical approach. *J Thorac Cardiovasc Surg* 2010;**140**:823-828.
- 5481 810. McClelland JH, Duke D, Reddy R. Preliminary results of a limited thoracotomy: new approach
5482 to treat atrial fibrillation. *J Cardiovasc Electrophysiol* 2007;**18**:1289-1295.
- 5483 811. Castella M, Pereda D, Mestres CA, Gomez F, Quintana E, Mulet J. Thoracoscopic pulmonary
5484 vein isolation in patients with atrial fibrillation and failed percutaneous ablation. *J Thorac Cardiovasc
5485 Surg* 2010;**140**:633-638.
- 5486 812. Krul SP, Driessen AH, van Boven WJ, Linnenbank AC, Geuzebroek GS, Jackman WM, Wilde
5487 AA, de Bakker JM, de Groot JR. Thoracoscopic video-assisted pulmonary vein antrum isolation,
5488 ganglionated plexus ablation, and periprocedural confirmation of ablation lesions: first results of a
5489 hybrid surgical-electrophysiological approach for atrial fibrillation. *Circ Arrhythm Electrophysiol*
5490 2011;**4**:262-270.
- 5491 813. La Meir M, Gelsomino S, Lorusso R, Luca F, Pison L, Parise O, Wellens F, Gensini GF,
5492 Maessen J. The hybrid approach for the surgical treatment of lone atrial fibrillation: one-year results
5493 employing a monopolar radiofrequency source. *J Cardiothorac Surg* 2012;**7**:71.
- 5494 814. Wang S, Liu L, Zou C. Comparative study of video-assisted thoracoscopic surgery ablation
5495 and radiofrequency catheter ablation on treating paroxysmal atrial fibrillation: a randomized, controlled
5496 short-term trial. *Chin Med J (Engl)* 2014;**127**:2567-2570.
- 5497 815. Phan K, Phan S, Thiagalingam A, Medi C, Yan TD. Thoracoscopic surgical ablation versus
5498 catheter ablation for atrial fibrillation. *Eur J Cardiothorac Surg* 2016;**49**:1044-1051.
- 5499 816. Hu QM, Li Y, Xu CL, Han J, Zhang HB, Han W, Meng X. Analysis of risk factors for
5500 recurrence after video-assisted pulmonary vein isolation of lone atrial fibrillation-results of 5 years of
5501 follow-up. *J Thorac Cardiovasc Surg* 2014;**148**:2174-2180.
- 5502 817. Edgerton JR, Edgerton ZJ, Weaver T, Reed K, Prince S, Herbert MA, Mack MJ. Minimally
5503 invasive pulmonary vein isolation and partial autonomic denervation for surgical treatment of atrial
5504 fibrillation. *Ann Thorac Surg* 2008;**86**:35-38; discussion 39.
- 5505 818. Wang J, Li Y, Shi J, Han J, Xu C, Ma C, Meng X. Minimally invasive surgical versus catheter
5506 ablation for the long-lasting persistent atrial fibrillation. *PLoS One* 2011;**6**:e22122.
- 5507 819. Wang JG, Xin M, Han J, Li Y, Luo TG, Wang J, Meng F, Meng X. Ablation in selective
5508 patients with long-standing persistent atrial fibrillation: medium-term results of the Dallas lesion set.
5509 *Eur J Cardiothorac Surg* 2014;**46**:213-220.

- 5510 820. Sirak JH, Schwartzman D. Interim results of the 5-box thoracoscopic maze procedure. *Ann Thorac Surg* 2012;**94**:1880-1884.
- 5511
- 5512 821. Kasirajan V, Spradlin EA, Mormando TE, Medina AE, Ovadia P, Schwartzman DS, Gaines TE, Mumtaz MA, Downing SW, Ellenbogen KA. Minimally invasive surgery using bipolar radiofrequency energy is effective treatment for refractory atrial fibrillation. *Ann Thorac Surg* 2012;**93**:1456-1461.
- 5513
- 5514
- 5515
- 5516 822. Weimar T, Vosseler M, Czesla M, Boscheinen M, Hemmer WB, Doll KN. Approaching a paradigm shift: endoscopic ablation of lone atrial fibrillation on the beating heart. *Ann Thorac Surg* 2012;**94**:1886-1892.
- 5517
- 5518
- 5519 823. La Meir M, Gelsomino S, Luca F, Pison L, Parise O, Colella A, Gensini GF, Crijns H, Wellens F, Maessen JG. Minimally invasive surgical treatment of lone atrial fibrillation: early results of hybrid versus standard minimally invasive approach employing radiofrequency sources. *Int J Cardiol* 2013;**167**:1469-1475.
- 5520
- 5521
- 5522
- 5523 824. Gelsomino S, Van Breugel HN, Pison L, Parise O, Crijns HJ, Wellens F, Maessen JG, La Meir M. Hybrid thoracoscopic and transvenous catheter ablation of atrial fibrillation. *Eur J Cardiothorac Surg* 2014;**45**:401-407.
- 5524
- 5525
- 5526 825. Pison L, La Meir M, van Opstal J, Blaauw Y, Maessen J, Crijns HJ. Hybrid thoracoscopic surgical and transvenous catheter ablation of atrial fibrillation. *J Am Coll Cardiol* 2012;**60**:54-61.
- 5527
- 5528 826. De Maat GE, Van Gelder IC, Rienstra M, Quast AF, Tan ES, Wiesfeld AC, Pozzoli A, Mariani MA. Surgical vs. transcatheter pulmonary vein isolation as first invasive treatment in patients with atrial fibrillation: a matched group comparison. *Europace* 2014;**16**:33-39.
- 5529
- 5530
- 5531 827. Vadmann H, Nielsen PB, Hjortshoj SP, Riahi S, Rasmussen LH, Lip GY, Larsen TB. Atrial flutter and thromboembolic risk: a systematic review. *Heart* 2015;**101**:1446-1455.
- 5532
- 5533 828. Stulak JM, Dearani JA, Daly RC, Zehr KJ, Sundt TM, 3rd, Schaff HV. Left ventricular dysfunction in atrial fibrillation: restoration of sinus rhythm by the Cox-maze procedure significantly improves systolic function and functional status. *Ann Thorac Surg* 2006;**82**:494-501.
- 5534
- 5535
- 5536 829. Chen YW, Bai R, Lin T, Salim M, Sang CH, Long DY, Yu RH, Tang RB, Guo XY, Yan XL, Nie JG, Du X, Dong JZ, Ma CS. Pacing or ablation: which is better for paroxysmal atrial fibrillation-related tachycardia-bradycardia syndrome? *Pacing Clin Electrophysiol* 2014;**37**:403-411.
- 5537
- 5538
- 5539 830. Khaykin Y, Marrouche NF, Martin DO, Saliba W, Schweikert R, Wexman M, Strunk B, Beheiry S, Saad E, Bhargava M, Burkhardt JD, Joseph G, Tchou P, Natale A. Pulmonary vein isolation for atrial fibrillation in patients with symptomatic sinus bradycardia or pauses. *J Cardiovasc Electrophysiol* 2004;**15**:784-789.
- 5540
- 5541
- 5542
- 5543 831. Ad N, Henry L, Hunt S. Current role for surgery in treatment of lone atrial fibrillation. *Semin Thorac Cardiovasc Surg* 2012;**24**:42-50.
- 5544
- 5545 832. Weimar T, Schena S, Bailey MS, Maniar HS, Schuessler RB, Cox JL, Damiano RJ, Jr. The cox-maze procedure for lone atrial fibrillation: a single-center experience over 2 decades. *Circ Arrhythm Electrophysiol* 2012;**5**:8-14.
- 5546
- 5547
- 5548 833. Ad N, Henry L, Hunt S, Holmes SD. Do we increase the operative risk by adding the Cox Maze III procedure to aortic valve replacement and coronary artery bypass surgery? *J Thorac Cardiovasc Surg* 2012;**143**:936-944.
- 5549
- 5550
- 5551 834. Prakash A, Saksena S, Krol RB, Filipecki A, Philip G. Catheter ablation of inducible atrial flutter, in combination with atrial pacing and antiarrhythmic drugs ("hybrid therapy") improves rhythm control in patients with refractory atrial fibrillation. *J Interv Card Electrophysiol* 2002;**6**:165-172.
- 5552
- 5553
- 5554 835. Tai CT, Chiang CE, Lee SH, Chen YJ, Yu WC, Feng AN, Ding YA, Chang MS, Chen SA. Persistent atrial flutter in patients treated for atrial fibrillation with amiodarone and propafenone: electrophysiologic characteristics, radiofrequency catheter ablation, and risk prediction [see comments]. *J Cardiovasc Electrophysiol* 1999;**10**:1180-1187.
- 5555
- 5556
- 5557
- 5558 836. Stabile G, De Simone A, Turco P, La Rocca V, Nocerino P, Astarita C, Maresca F, De Matteis C, Di Napoli T, Stabile E, Vitale DF. Response to flecainide infusion predicts long-term success of hybrid pharmacologic and ablation therapy in patients with atrial fibrillation. *J Am Coll Cardiol* 2001;**37**:1639-1644.
- 5559
- 5560
- 5561
- 5562 837. Anastasio N, Frankel DS, Deyell MW, Zado E, Gerstenfeld EP, Dixit S, Cooper J, Lin D, Marchlinski FE, Callans DJ. Nearly uniform failure of atrial flutter ablation and continuation of antiarrhythmic agents (hybrid therapy) for the long-term control of atrial fibrillation. *J Interv Card Electrophysiol* 2012;**35**:57-61.
- 5563
- 5564
- 5565
- 5566 838. Garcia Seara J, Raposeiras Roubin S, Gude Sampedro F, Balboa Barreiro V, Martinez Sande JL, Rodriguez Manero M, Gonzalez Juanatey JR. Failure of hybrid therapy for the prevention of long-term recurrence of atrial fibrillation. *Int J Cardiol* 2014;**176**:74-79.
- 5567
- 5568

- 5569 839. Saksena S, Prakash A, Ziegler P, Hummel JD, Friedman P, Plumb VJ, Wyse DG, Johnson E,
5570 Fitts S, Mehra R. Improved suppression of recurrent atrial fibrillation with dual-site right atrial pacing
5571 and antiarrhythmic drug therapy. *J Am Coll Cardiol* 2002;**40**:1140-1150; discussion 1151-1142.
- 5572 840. Wharton JM, Sorrentino RA, Campbell P, Gonzalez-Zuelgaray J, Keating E, Curtis A, Grill C,
5573 Hafley G, Lee K. Effect of pacing modality on atrial tachyarrhythmia recurrence in the tachycardia-
5574 bradycardia syndrome: preliminary results of the Pacemaker Atrial Tachycardia Trial. *Circulation*
5575 1998;**98 (suppl I)**:I-494 (abstract).
- 5576 841. Marinigh R, Lip GY, Fiotti N, Giansante C, Lane DA. Age as a risk factor for stroke in atrial
5577 fibrillation patients: implications for thromboprophylaxis. *J Am Coll Cardiol* 2010;**56**:827-837.
- 5578 842. Gage BF, Boechler M, Doggette AL, Fortune G, Flaker GC, Rich MW, Radford MJ. Adverse
5579 outcomes and predictors of underuse of antithrombotic therapy in medicare beneficiaries with chronic
5580 atrial fibrillation. *Stroke* 2000;**31**:822-827.
- 5581 843. Andreotti F, Rocca B, Husted S, Ajjan RA, Ten Berg J, Cattaneo M, Collet JP, De Caterina R,
5582 Fox KA, Halvorsen S, Huber K, Hylek EM, Lip GY, Montalescot G, Morais J, Patrono C, Verheugt FW,
5583 Wallentin L, Weiss TW, Storey RF, ESC Thrombosis Working Group. Antithrombotic therapy in the
5584 elderly: expert position paper of the European Society of Cardiology Working Group on Thrombosis.
5585 *Eur Heart J* 2015;**36**:3238-3249.
- 5586 844. Priori SG, Blomstrom-Lundqvist C, Mazzanti A, Blom N, Borggrefe M, Camm J, Elliott PM,
5587 Fitzsimons D, Hatala R, Hindricks G, Kirchhof P, Kjeldsen K, Kuck KH, Hernandez-Madrid A, Nikolaou
5588 N, Norekval TM, Spaulding C, Van Veldhuisen DJ. 2015 ESC Guidelines for the management of
5589 patients with ventricular arrhythmias and the prevention of sudden cardiac death: The Task Force for
5590 the Management of Patients with Ventricular Arrhythmias and the Prevention of Sudden Cardiac
5591 Death of the European Society of Cardiology (ESC). Endorsed by: Association for European
5592 Paediatric and Congenital Cardiology (AEPCC). *Eur Heart J* 2015;**36**:2793-2867.
- 5593 845. Elliott PM, Anastasakis A, Borger MA, Borggrefe M, Cecchi F, Charron P, Hagege AA, Lafont
5594 A, Limongelli G, Mahrholdt H, McKenna WJ, Mogensen J, Nihoyannopoulos P, Nistri S, Pieper PG,
5595 Pieske B, Rapezzi C, Rutten FH, Tillmanns C, Watkins H. 2014 ESC Guidelines on diagnosis and
5596 management of hypertrophic cardiomyopathy: the Task Force for the Diagnosis and Management of
5597 Hypertrophic Cardiomyopathy of the European Society of Cardiology (ESC). *Eur Heart J*
5598 2014;**35**:2733-2779.
- 5599 846. Johnson JN, Tester DJ, Perry J, Salisbury BA, Reed CR, Ackerman MJ. Prevalence of early-
5600 onset atrial fibrillation in congenital long QT syndrome. *Heart Rhythm* 2008;**5**:704-709.
- 5601 847. Kirchhof P, Eckardt L, Franz MR, Monnig G, Loh P, Wedekind H, Schulze-Bahr E, Breithardt
5602 G, Haverkamp W. Prolonged atrial action potential durations and polymorphic atrial tachyarrhythmias
5603 in patients with long QT syndrome. *J Cardiovasc Electrophysiol* 2003;**14**:1027-1033.
- 5604 848. Zellerhoff S, Pistulli R, Monnig G, Hinterseer M, Beckmann BM, Kobe J, Steinbeck G, Kaab
5605 S, Haverkamp W, Fabritz L, Gradaus R, Breithardt G, Schulze-Bahr E, Bocker D, Kirchhof P. Atrial
5606 Arrhythmias in long-QT syndrome under daily life conditions: a nested case control study. *J*
5607 *Cardiovasc Electrophysiol* 2009;**20**:401-407.
- 5608 849. Moss AJ, Zareba W, Benhorin J, Locati EH, Hall WJ, Robinson JL, Schwartz PJ, Towbin JA,
5609 Vincent GM, Lehmann MH. ECG T-wave patterns in genetically distinct forms of the hereditary long
5610 QT syndrome. *Circulation* 1995;**92**:2929-2934.
- 5611 850. Schwartz PJ, Priori SG, Spazzolini C, Moss AJ, Vincent GM, Napolitano C, Denjoy I,
5612 Guicheney P, Breithardt G, Keating MT, Towbin JA, Beggs AH, Brink P, Wilde AA, Toivonen L,
5613 Zareba W, Robinson JL, Timothy KW, Corfield V, Wattanasirichaigoon D, Corbett C, Haverkamp W,
5614 Schulze-Bahr E, Lehmann MH, Schwartz K, Coumel P, Bloise R. Genotype-phenotype correlation in
5615 the long-QT syndrome: gene-specific triggers for life-threatening arrhythmias. *Circulation*
5616 2001;**103**:89-95.
- 5617 851. Eckardt L, Kirchhof P, Loh P, Schulze-Bahr E, Johna R, Wichter T, Breithardt G, Haverkamp
5618 W, Borggrefe M. Brugada syndrome and supraventricular tachyarrhythmias: a novel association? *J*
5619 *Cardiovasc Electrophysiol* 2001;**12**:680-685.
- 5620 852. Kaufman ES. Mechanisms and clinical management of inherited channelopathies: long QT
5621 syndrome, Brugada syndrome, catecholaminergic polymorphic ventricular tachycardia, and short QT
5622 syndrome. *Heart Rhythm* 2009;**6**:S51-55.
- 5623 853. Antzelevitch C, Pollevick GD, Cordeiro JM, Casis O, Sanguinetti MC, Aizawa Y, Guerchicoff
5624 A, Pfeiffer R, Oliva A, Wollnik B, Gelber P, Bonaros EP, Jr., Burashnikov E, Wu Y, Sargent JD,
5625 Schickel S, Oberheiden R, Bhatia A, Hsu LF, Haissaguerre M, Schimpf R, Borggrefe M, Wolpert C.
5626 Loss-of-function mutations in the cardiac calcium channel underlie a new clinical entity characterized
5627 by ST-segment elevation, short QT intervals, and sudden cardiac death. *Circulation* 2007;**115**:442-
5628 449.

- 5629 854. London B, Michalec M, Mehdi H, Zhu X, Kerchner L, Sanyal S, Viswanathan PC, Pfahnl AE,
5630 Shang LL, Madhusudanan M, Baty CJ, Lagana S, Aleong R, Gutmann R, Ackerman MJ, McNamara
5631 DM, Weiss R, Dudley SC, Jr. Mutation in glycerol-3-phosphate dehydrogenase 1 like gene (GPD1-L)
5632 decreases cardiac Na⁺ current and causes inherited arrhythmias. *Circulation* 2007;**116**:2260-2268.
- 5633 855. Watanabe H, Koopmann TT, Le Scouarnec S, Yang T, Ingram CR, Schott JJ, Demolombe S,
5634 Probst V, Anselme F, Escande D, Wiesfeld AC, Pfeufer A, Kaab S, Wichmann HE, Hasdemir C,
5635 Aizawa Y, Wilde AA, Roden DM, Bezzina CR. Sodium channel beta1 subunit mutations associated
5636 with Brugada syndrome and cardiac conduction disease in humans. *J Clin Invest* 2008;**118**:2260-
5637 2268.
- 5638 856. Brugada R, Hong K, Dumaine R, Cordeiro J, Gaita F, Borggrefe M, Menendez TM, Brugada
5639 J, Pollevick GD, Wolpert C, Burashnikov E, Matsuo K, Wu YS, Guerchicoff A, Bianchi F, Giustetto C,
5640 Schimpf R, Brugada P, Antzelevitch C. Sudden death associated with short-QT syndrome linked to
5641 mutations in HERG. *Circulation* 2004;**109**:30-35.
- 5642 857. Gaita F, Giustetto C, Bianchi F, Wolpert C, Schimpf R, Riccardi R, Grossi S, Richiardi E,
5643 Borggrefe M. Short QT Syndrome: a familial cause of sudden death. *Circulation* 2003;**108**:965-970.
- 5644 858. Giustetto C, Di Monte F, Wolpert C, Borggrefe M, Schimpf R, Sbragia P, Leone G, Maury P,
5645 Anttonen O, Haissaguerre M, Gaita F. Short QT syndrome: clinical findings and diagnostic-therapeutic
5646 implications. *Eur Heart J* 2006;**27**:2440-2447.
- 5647 859. Bhuiyan ZA, van den Berg MP, van Tintelen JP, Bink-Boelkens MT, Wiesfeld AC, Alders M,
5648 Postma AV, van Langen I, Mannens MM, Wilde AA. Expanding spectrum of human RYR2-related
5649 disease: new electrocardiographic, structural, and genetic features. *Circulation* 2007;**116**:1569-1576.
- 5650 860. Napolitano C, Priori SG. Diagnosis and treatment of catecholaminergic polymorphic
5651 ventricular tachycardia. *Heart Rhythm* 2007;**4**:675-678.
- 5652 861. Mohamed U, Napolitano C, Priori SG. Molecular and electrophysiological bases of
5653 catecholaminergic polymorphic ventricular tachycardia. *J Cardiovasc Electrophysiol* 2007;**18**:791-797.
- 5654 862. Lee CH, Liu PY, Lin LJ, Chen JH, Tsai LM. Clinical characteristics and outcomes of
5655 hypertrophic cardiomyopathy in Taiwan--a tertiary center experience. *Clin Cardiol* 2007;**30**:177-182.
- 5656 863. Losi MA, Betocchi S, Aversa M, Lombardi R, Miranda M, D'Alessandro G, Cacace A,
5657 Tocchetti CG, Barbati G, Chiariello M. Determinants of atrial fibrillation development in patients with
5658 hypertrophic cardiomyopathy. *Am J Cardiol* 2004;**94**:895-900.
- 5659 864. Maron BJ, Olivetto I, Bellone P, Conte MR, Cecchi F, Flygenring BP, Casey SA, Gohman TE,
5660 Bongioanni S, Spirito P. Clinical profile of stroke in 900 patients with hypertrophic cardiomyopathy. *J*
5661 *Am Coll Cardiol* 2002;**39**:301-307.
- 5662 865. Gollob MH, Seger JJ, Gollob TN, Tapscott T, Gonzales O, Bachinski L, Roberts R. Novel
5663 PRKAG2 mutation responsible for the genetic syndrome of ventricular preexcitation and conduction
5664 system disease with childhood onset and absence of cardiac hypertrophy. *Circulation* 2001;**104**:3030-
5665 3033.
- 5666 866. Postma AV, van de Meerakker JB, Mathijssen IB, Barnett P, Christoffels VM, Ilgun A, Lam J,
5667 Wilde AA, Lekanne Deprez RH, Moorman AF. A gain-of-function TBX5 mutation is associated with
5668 atypical Holt-Oram syndrome and paroxysmal atrial fibrillation. *Circ Res* 2008;**102**:1433-1442.
- 5669 867. Marcus FI, Edson S, Towbin JA. Genetics of arrhythmogenic right ventricular cardiomyopathy:
5670 a practical guide for physicians. *J Am Coll Cardiol* 2013;**61**:1945-1948.
- 5671 868. Chu AF, Zado E, Marchlinski FE. Atrial arrhythmias in patients with arrhythmogenic right
5672 ventricular cardiomyopathy/dysplasia and ventricular tachycardia. *Am J Cardiol* 2010;**106**:720-722.
- 5673 869. Blomstrom-Lundqvist C, Scheinman MM, Aliot EM, Alpert JS, Calkins H, Camm AJ, Campbell
5674 WB, Haines DE, Kuck KH, Lerman BB, Miller DD, Shaeffer CW, Stevenson WG, Tomaselli GF,
5675 Antman EM, Smith SC, Jr., Alpert JS, Faxon DP, Fuster V, Gibbons RJ, Gregoratos G, Hiratzka LF,
5676 Hunt SA, Jacobs AK, Russell RO, Jr., Priori SG, Blanc JJ, Budaj A, Burgos EF, Cowie M, Deckers
5677 JW, Garcia MA, Klein WW, Lekakis J, Lindahl B, Mazzotta G, Morais JC, Oto A, Smiseth O, Trappe
5678 HJ, European Society of Cardiology Committee, NASPE-Heart Rhythm Society. ACC/AHA/ESC
5679 guidelines for the management of patients with supraventricular arrhythmias--executive summary. a
5680 report of the American college of cardiology/American heart association task force on practice
5681 guidelines and the European society of cardiology committee for practice guidelines (writing
5682 committee to develop guidelines for the management of patients with supraventricular arrhythmias)
5683 developed in collaboration with NASPE-Heart Rhythm Society. *J Am Coll Cardiol* 2003;**42**:1493-1531.
- 5684 870. Tischenko A, Fox DJ, Yee R, Krahn AD, Skanes AC, Gula LJ, Klein GJ. When should we
5685 recommend catheter ablation for patients with the Wolff-Parkinson-White syndrome? *Curr Opin*
5686 *Cardiol* 2008;**23**:32-37.
- 5687 871. Kibos A, Deharo JC, Adoubi A, Assouan X, Djiane P. [Clinical and electrophysiological study
5688 of asymptomatic Wolff-Parkinson-White syndrome]. *Ann Cardiol Angeiol (Paris)* 2007;**56**:237-240.

- 5689 872. Pappone C, Santinelli V, Manguso F, Augello G, Santinelli O, Vicedomini G, Gulletta S,
5690 Mazzone P, Tortoriello V, Pappone A, Dicandia C, Rosanio S. A randomized study of prophylactic
5691 catheter ablation in asymptomatic patients with the Wolff-Parkinson-White syndrome. *N Engl J Med*
5692 2003;**349**:1803-1811.
- 5693 873. Boahene KA, Klein GJ, Yee R, Sharma AD, Fujimura O. Termination of acute atrial fibrillation
5694 in the Wolff-Parkinson-White syndrome by procainamide and propafenone: importance of atrial
5695 fibrillatory cycle length. *J Am Coll Cardiol* 1990;**16**:1408-1414.
- 5696 874. O'Nunain S, Garratt CJ, Linker NJ, Gill J, Ward DE, Camm AJ. A comparison of intravenous
5697 propafenone and flecainide in the treatment of tachycardias associated with the Wolff-Parkinson-
5698 White syndrome. *Pacing Clin Electrophysiol* 1991;**14**:2028-2034.
- 5699 875. Manolis AS, Estes NA, 3rd. Supraventricular tachycardia. Mechanisms and therapy. *Arch*
5700 *Intern Med* 1987;**147**:1706-1716.
- 5701 876. Simonian SM, Lotfipour S, Wall C, Langdorf MI. Challenging the superiority of amiodarone for
5702 rate control in Wolff-Parkinson-White and atrial fibrillation. *Intern Emerg Med* 2010;**5**:421-426.
- 5703 877. Guttman OP, Rahman MS, O'Mahony C, Anastasakis A, Elliott PM. Atrial fibrillation and
5704 thromboembolism in patients with hypertrophic cardiomyopathy: systematic review. *Heart*
5705 2014;**100**:465-472.
- 5706 878. Olivetto I, Cecchi F, Casey SA, Dolara A, Traverse JH, Maron BJ. Impact of atrial fibrillation
5707 on the clinical course of hypertrophic cardiomyopathy. *Circulation* 2001;**104**:2517-2524.
- 5708 879. Cecchi F, Olivetto I, Monteregeggi A, Squillatini G, Dolara A, Maron BJ. Prognostic value of non-
5709 sustained ventricular tachycardia and the potential role of amiodarone treatment in hypertrophic
5710 cardiomyopathy: assessment in an unselected non-referral based patient population. *Heart*
5711 1998;**79**:331-336.
- 5712 880. Bunch TJ, Munger TM, Friedman PA, Asirvatham SJ, Brady PA, Cha YM, Rea RF, Shen WK,
5713 Powell BD, Ommen SR, Monahan KH, Haroldson JM, Packer DL. Substrate and procedural
5714 predictors of outcomes after catheter ablation for atrial fibrillation in patients with hypertrophic
5715 cardiomyopathy. *J Cardiovasc Electrophysiol* 2008;**19**:1009-1014.
- 5716 881. Di Donna P, Olivetto I, Delcre SD, Caponi D, Scaglione M, Nault I, Montefusco A, Girolami F,
5717 Cecchi F, Haissaguerre M, Gaita F. Efficacy of catheter ablation for atrial fibrillation in hypertrophic
5718 cardiomyopathy: impact of age, atrial remodelling, and disease progression. *Europace* 2010;**12**:347-
5719 355.
- 5720 882. Gaita F, Di Donna P, Olivetto I, Scaglione M, Ferrero I, Montefusco A, Caponi D, Conte MR,
5721 Nistri S, Cecchi F. Usefulness and safety of transcatheter ablation of atrial fibrillation in patients with
5722 hypertrophic cardiomyopathy. *Am J Cardiol* 2007;**99**:1575-1581.
- 5723 883. Kilicaslan F, Verma A, Saad E, Themistoclakis S, Bonso A, Raviele A, Bozbas H, Andrews
5724 MW, Beheiry S, Hao S, Cummings JE, Marrouche NF, Lakkireddy D, Wazni O, Yamaji H, Saenz LC,
5725 Saliba W, Schweikert RA, Natale A. Efficacy of catheter ablation of atrial fibrillation in patients with
5726 hypertrophic obstructive cardiomyopathy. *Heart Rhythm* 2006;**3**:275-280.
- 5727 884. McCready JW, Smedley T, Lambiase PD, Ahsan SY, Segal OR, Rowland E, Lowe MD, Chow
5728 AW. Predictors of recurrence following radiofrequency ablation for persistent atrial fibrillation.
5729 *Europace* 2011;**13**:355-361.
- 5730 885. Ritchie MD, Rowan S, Kucera G, Stubblefield T, Blair M, Carter S, Roden DM, Darbar D.
5731 Chromosome 4q25 variants are genetic modifiers of rare ion channel mutations associated with
5732 familial atrial fibrillation. *J Am Coll Cardiol* 2012;**60**:1173-1181.
- 5733 886. Mann SA, Otway R, Guo G, Soka M, Karlsdotter L, Trivedi G, Ohanian M, Zodgekar P, Smith
5734 RA, Wouters MA, Subbiah R, Walker B, Kuchar D, Sanders P, Griffiths L, Vandenberg JI, Fatkin D.
5735 Epistatic effects of potassium channel variation on cardiac repolarization and atrial fibrillation risk. *J*
5736 *Am Coll Cardiol* 2012;**59**:1017-1025.
- 5737 887. Giustetto C, Cerrato N, Gribaudo E, Scrocco C, Castagno D, Richiardi E, Giachino D, Bianchi
5738 F, Barbonaglia L, Ferraro A. Atrial fibrillation in a large population with Brugada electrocardiographic
5739 pattern: prevalence, management, and correlation with prognosis. *Heart Rhythm* 2014;**11**:259-265.
- 5740 888. Darbar D, Kannankeril PJ, Donahue BS, Kucera G, Stubblefield T, Haines JL, George AL, Jr.,
5741 Roden DM. Cardiac sodium channel (SCN5A) variants associated with atrial fibrillation. *Circulation*
5742 2008;**117**:1927-1935.
- 5743 889. Olson TM, Michels VV, Ballew JD, Reyna SP, Karst ML, Herron KJ, Horton SC, Rodeheffer
5744 RJ, Anderson JL. Sodium channel mutations and susceptibility to heart failure and atrial fibrillation.
5745 *JAMA* 2005;**293**:447-454.
- 5746 890. Ellinor PT, Moore RK, Patton KK, Ruskin JN, Pollak MR, Macrae CA. Mutations in the long
5747 QT gene, KCNQ1, are an uncommon cause of atrial fibrillation. *Heart* 2004;**90**:1487-1488.

- 5748 891. Priori SG, Wilde AA, Horie M, Cho Y, Behr ER, Berul C, Blom N, Brugada J, Chiang CE,
5749 Huikuri H, Kannankeril P, Krahn A, Leenhardt A, Moss A, Schwartz PJ, Shimizu W, Tomaselli G,
5750 Tracy C, Ackerman M, Belhassen B, Estes NA, 3rd, Fatkin D, Kalman J, Kaufman E, Kirchhof P,
5751 Schulze-Bahr E, Wolpert C, Vohra J, Refaat M, Etheridge SP, Campbell RM, Martin ET, Quek SC.
5752 Executive summary: HRS/EHRA/APHRS expert consensus statement on the diagnosis and
5753 management of patients with inherited primary arrhythmia syndromes. *Europace* 2013;**15**:1389-1406.
- 5754 892. Antz M, Weiss C, Volkmer M, Hebe J, Ernst S, Ouyang F, Kuck KH. Risk of sudden death
5755 after successful accessory atrioventricular pathway ablation in resuscitated patients with Wolff-
5756 Parkinson-White syndrome. *J Cardiovasc Electrophysiol* 2002;**13**:231-236.
- 5757 893. Timmermans C, Smeets JL, Rodriguez LM, Vrouchos G, van den Dool A, Wellens HJ.
5758 Aborted sudden death in the Wolff-Parkinson-White syndrome. *Am J Cardiol* 1995;**76**:492-494.
- 5759 894. Bromberg BI, Lindsay BD, Cain ME, Cox JL. Impact of clinical history and electrophysiologic
5760 characterization of accessory pathways on management strategies to reduce sudden death among
5761 children with Wolff-Parkinson-White syndrome. *J Am Coll Cardiol* 1996;**27**:690-695.
- 5762 895. Al-Khatib SM, Arshad A, Balk EM, Das SR, Hsu JC, Joglar JA, Page RL. Risk stratification for
5763 arrhythmic events in patients with asymptomatic pre-excitation: A systematic review for the 2015
5764 ACC/AHA/HRS guideline for the management of adult patients with supraventricular tachycardia: A
5765 Report of the American College of Cardiology/American Heart Association Task Force on Clinical
5766 Practice Guidelines and the Heart Rhythm Society. *Heart Rhythm* 2016;**13**:e222-237.
- 5767 896. Maron BJ, Ommen SR, Semsarian C, Spirito P, Olivetto I, Maron MS. Hypertrophic
5768 cardiomyopathy: present and future, with translation into contemporary cardiovascular medicine. *J Am
5769 Coll Cardiol* 2014;**64**:83-99.
- 5770 897. Robinson K, Frenneaux MP, Stockins B, Karatasakis G, Poloniecki JD, McKenna WJ. Atrial
5771 fibrillation in hypertrophic cardiomyopathy: a longitudinal study. *J Am Coll Cardiol* 1990;**15**:1279-1285.
- 5772 898. Mozaffarian D, Furberg CD, Psaty BM, Siscovick D. Physical activity and incidence of atrial
5773 fibrillation in older adults: the cardiovascular health study. *Circulation* 2008;**118**:800-807.
- 5774 899. Elosua R, Arquer A, Mont L, Sambola A, Molina L, Garcia-Moran E, Brugada J, Marrugat J.
5775 Sport practice and the risk of lone atrial fibrillation: a case-control study. *Int J Cardiol* 2006;**108**:332-
5776 337.
- 5777 900. Mont L, Sambola A, Brugada J, Vacca M, Marrugat J, Elosua R, Pare C, Azqueta M, Sanz G.
5778 Long-lasting sport practice and lone atrial fibrillation. *Eur Heart J* 2002;**23**:477-482.
- 5779 901. Abdulla J, Nielsen JR. Is the risk of atrial fibrillation higher in athletes than in the general
5780 population? A systematic review and meta-analysis. *Europace* 2009;**11**:1156-1159.
- 5781 902. Thelle DS, Selmer R, Gjesdal K, Sakshaug S, Jugessur A, Graff-Iversen S, Tverdal A, Nystad
5782 W. Resting heart rate and physical activity as risk factors for lone atrial fibrillation: a prospective study
5783 of 309,540 men and women. *Heart* 2013;**99**:1755-1760.
- 5784 903. Wilhelm M, Roten L, Tanner H, Wilhelm I, Schmid JP, Saner H. Atrial remodeling, autonomic
5785 tone, and lifetime training hours in nonelite athletes. *Am J Cardiol* 2011;**108**:580-585.
- 5786 904. Guasch E, Benito B, Qi X, Cifelli C, Naud P, Shi Y, Mighiu A, Tardif JC, Tadevosyan A, Chen
5787 Y, Gillis MA, Iwasaki YK, Dobrev D, Mont L, Heximer S, Nattel S. Atrial fibrillation promotion by
5788 endurance exercise: demonstration and mechanistic exploration in an animal model. *J Am Coll
5789 Cardiol* 2013;**62**:68-77.
- 5790 905. Andersen K, Farahmand B, Ahlbom A, Held C, Ljunghall S, Michaelsson K, Sundstrom J.
5791 Risk of arrhythmias in 52 755 long-distance cross-country skiers: a cohort study. *Eur Heart J
5792* 2013;**34**:3624-3631.
- 5793 906. Karjalainen J, Kujala UM, Kaprio J, Sarna S, Viitasalo M. Lone atrial fibrillation in vigorously
5794 exercising middle aged men: case-control study. *BMJ* 1998;**316**:1784-1785.
- 5795 907. Biffi A, Maron BJ, Culasso F, Verdile L, Fernando F, Di Giacinto B, Di Paolo FM, Spataro A,
5796 Delise P, Pelliccia A. Patterns of ventricular tachyarrhythmias associated with training, deconditioning
5797 and retraining in elite athletes without cardiovascular abnormalities. *Am J Cardiol* 2011;**107**:697-703.
- 5798 908. Calvo N, Mont L, Tamborero D, Berruezo A, Viola G, Guasch E, Nadal M, Andreu D, Vidal B,
5799 Sitges M, Brugada J. Efficacy of circumferential pulmonary vein ablation of atrial fibrillation in
5800 endurance athletes. *Europace* 2010;**12**:30-36.
- 5801 909. Koopman P, Nuyens D, Garweg C, La Gerche A, De Buck S, Van Casteren L, Alzand B,
5802 Willems R, Heidebuchel H. Efficacy of radiofrequency catheter ablation in athletes with atrial fibrillation.
5803 *Europace* 2011;**13**:1386-1393.
- 5804 910. Heidebuchel H, Panhuyzen-Goedkoop N, Corrado D, Hoffmann E, Biffi A, Delise P,
5805 Blomstrom-Lundqvist C, Vanhees L, Ivarhoff P, Dorwarth U, Pelliccia A. Recommendations for
5806 participation in leisure-time physical activity and competitive sports in patients with arrhythmias and

- 5807 potentially arrhythmogenic conditions Part I: Supraventricular arrhythmias and pacemakers. *Eur J*
5808 *Cardiovasc Prev Rehabil* 2006;**13**:475-484.
- 5809 911. Silversides CK, Harris L, Haberer K, Sermer M, Colman JM, Siu SC. Recurrence rates of
5810 arrhythmias during pregnancy in women with previous tachyarrhythmia and impact on fetal and
5811 neonatal outcomes. *Am J Cardiol* 2006;**97**:1206-1212.
- 5812 912. Salam AM, Ertekin E, van Hagen IM, Al Suwaidi J, Ruys TPE, Johnson MR, Gumbiene L,
5813 Frogoudaki AA, Sorour KA, Iserin L, Ladouceur M, van Oppen ACC, Hall R, Roos-Hesselink JW.
5814 Atrial Fibrillation or Flutter During Pregnancy in Patients With Structural Heart Disease: Data From the
5815 ROPAC (Registry on Pregnancy and Cardiac Disease). *JACC Clin Electrophysiol* 2015;**1**:284-292.
- 5816 913. Baumgartner H, Bonhoeffer P, De Groot NM, de Haan F, Deanfield JE, Galie N, Gatzoulis
5817 MA, Gohlke-Baerwolf C, Kaemmerer H, Kilner P, Meijboom F, Mulder BJ, Oechslin E, Oliver JM,
5818 Serraf A, Szatmari A, Thaulow E, Vouhe PR, Walma E. ESC Guidelines for the management of
5819 grown-up congenital heart disease (new version 2010). *Eur Heart J* 2010;**31**:2915-2957.
- 5820 914. Page RL. Treatment of arrhythmias during pregnancy. *Am Heart J* 1995;**130**:871-876.
- 5821 915. Magee LA, Duley L. Oral beta-blockers for mild to moderate hypertension during pregnancy.
5822 *Cochrane Database Syst Rev* 2003;**3**:CD002863.
- 5823 916. Mitani GM, Steinberg I, Lien EJ, Harrison EC, Elkayam U. The pharmacokinetics of
5824 antiarrhythmic agents in pregnancy and lactation. *Clin Pharmacokinet* 1987;**12**:253-291.
- 5825 917. Gowda RM, Khan IA, Mehta NJ, Vasavada BC, Sacchi TJ. Cardiac arrhythmias in pregnancy:
5826 clinical and therapeutic considerations. *Int J Cardiol* 2003;**88**:129-133.
- 5827 918. Joint Formulary Committee. *British National Formulary (online)*.
5828 <http://www.medicinescomplete.com>. Date last accessed 02/12/2014 2014
- 5829 919. Bartalena L, Bogazzi F, Braverman LE, Martino E. Effects of amiodarone administration
5830 during pregnancy on neonatal thyroid function and subsequent neurodevelopment. *J Endocrinol*
5831 *Invest* 2001;**24**:116-130.
- 5832 920. Jaeggi ET, Carvalho JS, De Groot E, Api O, Clur SA, Rammeloo L, McCrindle BW, Ryan G,
5833 Manlhiot C, Blom NA. Comparison of transplacental treatment of fetal supraventricular
5834 tachyarrhythmias with digoxin, flecainide, and sotalol: results of a nonrandomized multicenter study.
5835 *Circulation* 2011;**124**:1747-1754.
- 5836 921. Tromp CHN, Nanne ACM, Pernet PJM, Tukkie R, Bolte AC. Electrical cardioversion during
5837 pregnancy: safe or not? *Neth Heart J* 2011;**19**:134-136.
- 5838 922. Ghosh N, Luk A, Derzko C, Dorian P, Chow CM. The acute treatment of maternal
5839 supraventricular tachycardias during pregnancy: a review of the literature. *J Obstet Gynaecol Can*
5840 2011;**33**:17-23.
- 5841 923. Bates SM, Greer IA, Middeldorp S, Veenstra DL, Prabulos AM, Vandvik PO, American
5842 College of Chest Physicians. VTE, thrombophilia, antithrombotic therapy, and pregnancy:
5843 Antithrombotic Therapy and Prevention of Thrombosis, 9th ed: American College of Chest Physicians
5844 Evidence-Based Clinical Practice Guidelines. *Chest* 2012;**141**:e691S-736S.
- 5845 924. Ahlsson AJ, Bodin L, Lundblad OH, Englund AG. Postoperative atrial fibrillation is not
5846 correlated to C-reactive protein. *Ann Thorac Surg* 2007;**83**:1332-1337.
- 5847 925. Arsenault KA, Yusuf AM, Crystal E, Healey JS, Morillo CA, Nair GM, Whitlock RP.
5848 Interventions for preventing postoperative atrial fibrillation in patients undergoing heart surgery.
5849 *Cochrane Database Syst Rev* 2013;**1**:Cd003611.
- 5850 926. Mathew JP, Fontes ML, Tudor IC, Ramsay J, Duke P, Mazer CD, Barash PG, Hsu PH,
5851 Mangano DT. A multicenter risk index for atrial fibrillation after cardiac surgery. *JAMA* 2004;**291**:1720-
5852 1729.
- 5853 927. Steinberg BA, Zhao Y, He X, Hernandez AF, Fullerton DA, Thomas KL, Mills R, Klaskala W,
5854 Peterson ED, Piccini JP. Management of postoperative atrial fibrillation and subsequent outcomes in
5855 contemporary patients undergoing cardiac surgery: insights from the Society of Thoracic Surgeons
5856 CAPS-Care Atrial Fibrillation Registry. *Clin Cardiol* 2014;**37**:7-13.
- 5857 928. Khan MF, Wendel CS, Movahed MR. Prevention of post-coronary artery bypass grafting
5858 (CABG) atrial fibrillation: efficacy of prophylactic beta-blockers in the modern era: a meta-analysis of
5859 latest randomized controlled trials. *Ann Noninvasive Electrocardiol* 2013;**18**:58-68.
- 5860 929. Burgess DC, Kilborn MJ, Keech AC. Interventions for prevention of post-operative atrial
5861 fibrillation and its complications after cardiac surgery: a meta-analysis. *Eur Heart J* 2006;**27**:2846-
5862 2857.
- 5863 930. Chatterjee S, Sardar P, Mukherjee D, Lichstein E, Aikat S. Timing and route of amiodarone
5864 for prevention of postoperative atrial fibrillation after cardiac surgery: a network regression meta-
5865 analysis. *Pacing Clin Electrophysiol* 2013;**36**:1017-1023.

- 5866 931. Zhu J, Wang C, Gao D, Zhang C, Zhang Y, Lu Y, Gao Y. Meta-analysis of amiodarone versus
5867 beta-blocker as a prophylactic therapy against atrial fibrillation following cardiac surgery. *Intern Med J*
5868 2012;**42**:1078-1087.
- 5869 932. Fauchier L, Clementy N, Babuty D. Statin therapy and atrial fibrillation: systematic review and
5870 updated meta-analysis of published randomized controlled trials. *Curr Opin Cardiol* 2013;**28**:7-18.
- 5871 933. Zheng H, Xue S, Hu ZL, Shan JG, Yang WG. The use of statins to prevent postoperative
5872 atrial fibrillation after coronary artery bypass grafting: a meta-analysis of 12 studies. *J Cardiovasc*
5873 *Pharmacol* 2014;**64**:285-292.
- 5874 934. Casadei B, OTHERS. Statin Therapy In Cardiac Surgery (STICS) Trial. *N Engl J Med*
5875 2016;**TO BE ADDED**.
- 5876 935. Cook RC, Yamashita MH, Kearns M, Ramanathan K, Gin K, Humphries KH. Prophylactic
5877 magnesium does not prevent atrial fibrillation after cardiac surgery: a meta-analysis. *Ann Thorac Surg*
5878 2013;**95**:533-541.
- 5879 936. De Oliveira GS, Jr., Knautz JS, Sherwani S, McCarthy RJ. Systemic magnesium to reduce
5880 postoperative arrhythmias after coronary artery bypass graft surgery: a meta-analysis of randomized
5881 controlled trials. *J Cardiothorac Vasc Anesth* 2012;**26**:643-650.
- 5882 937. Costanzo S, di Niro V, Di Castelnuovo A, Gianfagna F, Donati MB, de Gaetano G, Iacoviello
5883 L. Prevention of postoperative atrial fibrillation in open heart surgery patients by preoperative
5884 supplementation of n-3 polyunsaturated fatty acids: an updated meta-analysis. *J Thorac Cardiovasc*
5885 *Surg* 2013;**146**:906-911.
- 5886 938. Farquharson AL, Metcalf RG, Sanders P, Stuklis R, Edwards JR, Gibson RA, Cleland LG,
5887 Sullivan TR, James MJ, Young GD. Effect of dietary fish oil on atrial fibrillation after cardiac surgery.
5888 *Am J Cardiol* 2011;**108**:851-856.
- 5889 939. Heidarsdottir R, Arnar DO, Skuladottir GV, Torfason B, Edvardsson V, Gottskalksson G,
5890 Palsson R, Indridason OS. Does treatment with n-3 polyunsaturated fatty acids prevent atrial
5891 fibrillation after open heart surgery? *Europace* 2010;**12**:356-363.
- 5892 940. Mariani J, Doval HC, Nul D, Varini S, Grancelli H, Ferrante D, Tognoni G, Macchia A. N-3
5893 polyunsaturated fatty acids to prevent atrial fibrillation: updated systematic review and meta-analysis
5894 of randomized controlled trials. *J Am Heart Assoc* 2013;**2**:e005033.
- 5895 941. Rodrigo R, Korantzopoulos P, Cereceda M, Asenjo R, Zamorano J, Villalabeitia E, Baeza C,
5896 Aguayo R, Castillo R, Carrasco R, Gormaz JG. A randomized controlled trial to prevent post-operative
5897 atrial fibrillation by antioxidant reinforcement. *J Am Coll Cardiol* 2013;**62**:1457-1465.
- 5898 942. Saravanan P, Bridgewater B, West AL, O'Neill SC, Calder PC, Davidson NC. Omega-3 fatty
5899 acid supplementation does not reduce risk of atrial fibrillation after coronary artery bypass surgery: a
5900 randomized, double-blind, placebo-controlled clinical trial. *Circ Arrhythm Electrophysiol* 2010;**3**:46-53.
- 5901 943. Wu JH, Marchioli R, Silletta MG, Macchia A, Song X, Siscovick DS, Harris WS, Masson S,
5902 Latini R, Albert C, Brown NJ, Lamarra M, Favalaro RR, Mozaffarian D. Plasma phospholipid omega-3
5903 fatty acids and incidence of postoperative atrial fibrillation in the OPERA trial. *J Am Heart Assoc*
5904 2013;**2**:e000397.
- 5905 944. Xin W, Wei W, Lin Z, Zhang X, Yang H, Zhang T, Li B, Mi S. Fish oil and atrial fibrillation after
5906 cardiac surgery: a meta-analysis of randomized controlled trials. *PLoS One* 2013;**8**:e72913.
- 5907 945. Zhang B, Zhen Y, Tao A, Bao Z, Zhang G. Polyunsaturated fatty acids for the prevention of
5908 atrial fibrillation after cardiac surgery: an updated meta-analysis of randomized controlled trials. *J*
5909 *Cardiol* 2014;**63**:53-59.
- 5910 946. Imazio M, Brucato A, Ferrazzi P, Pullara A, Adler Y, Barosi A, Caforio AL, Cemin R, Chirillo F,
5911 Comoglio C, Cugola D, Cumetti D, Dyrda O, Ferrua S, Finkelstein Y, Flocco R, Gandino A, Hoit B,
5912 Innocente F, Maestroni S, Musumeci F, Oh J, Pergolini A, Polizzi V, Ristic A, Simon C, Spodick DH,
5913 Tarzia V, Trimboli S, Valenti A, Belli R, Gaita F, COPPS-2 Investigators. Colchicine for prevention of
5914 postpericardiotomy syndrome and postoperative atrial fibrillation: the COPPS-2 randomized clinical
5915 trial. *JAMA* 2014;**312**:1016-1023.
- 5916 947. Cappabianca G, Rotunno C, de Luca Tuppiti Schinosa L, Ranieri VM, Paparella D. Protective
5917 effects of steroids in cardiac surgery: a meta-analysis of randomized double-blind trials. *J*
5918 *Cardiothorac Vasc Anesth* 2011;**25**:156-165.
- 5919 948. Viviano A, Kanagasabay R, Zakkar M. Is perioperative corticosteroid administration
5920 associated with a reduced incidence of postoperative atrial fibrillation in adult cardiac surgery?
5921 *Interact Cardiovasc Thorac Surg* 2014;**18**:225-229.
- 5922 949. Kaleda VI, McCormack DJ, Shipolini AR. Does posterior pericardiotomy reduce the incidence
5923 of atrial fibrillation after coronary artery bypass grafting surgery? *Interact Cardiovasc Thorac Surg*
5924 2012;**14**:384-389.

- 5925 950. Dunning J, Treasure T, Versteegh M, Nashef SA. Guidelines on the prevention and
5926 management of de novo atrial fibrillation after cardiac and thoracic surgery. *Eur J Cardiothorac Surg*
5927 2006;**30**:852-872.
- 5928 951. LaPar DJ, Speir AM, Crosby IK, Fonner E, Jr., Brown M, Rich JB, Quader M, Kern JA, Kron
5929 IL, Ailawadi G, Investigators for the Virginia Cardiac Surgery Quality Initiative. Postoperative atrial
5930 fibrillation significantly increases mortality, hospital readmission, and hospital costs. *Ann Thorac Surg*
5931 2014;**98**:527-533; discussion 533.
- 5932 952. Saxena A, Dinh DT, Smith JA, Shardey GC, Reid CM, Newcomb AE. Usefulness of
5933 postoperative atrial fibrillation as an independent predictor for worse early and late outcomes after
5934 isolated coronary artery bypass grafting (multicenter Australian study of 19,497 patients). *Am J*
5935 *Cardiol* 2012;**109**:219-225.
- 5936 953. Gialdini G, Nearing K, Bhavne PD, Bonuccelli U, Iadecola C, Healey JS, Kamel H.
5937 Perioperative atrial fibrillation and the long-term risk of ischemic stroke. *JAMA* 2014;**312**:616-622.
- 5938 954. Ahlsson A, Bodin L, Fengsrud E, Englund A. Patients with postoperative atrial fibrillation have
5939 a doubled cardiovascular mortality. *Scand Cardiovasc J* 2009;**43**:330-336.
- 5940 955. Ahlsson A, Fengsrud E, Bodin L, Englund A. Postoperative atrial fibrillation in patients
5941 undergoing aortocoronary bypass surgery carries an eightfold risk of future atrial fibrillation and a
5942 doubled cardiovascular mortality. *Eur J Cardiothorac Surg* 2010;**37**:1353-1359.
- 5943 956. Mariscalco G, Klersy C, Zanobini M, Banach M, Ferrarese S, Borsani P, Cantore C, Biglioli P,
5944 Sala A. Atrial fibrillation after isolated coronary surgery affects late survival. *Circulation*
5945 2008;**118**:1612-1618.
- 5946 957. Villareal RP, Hariharan R, Liu BC, Kar B, Lee VV, Elayda M, Lopez JA, Rasekh A, Wilson JM,
5947 Massumi A. Postoperative atrial fibrillation and mortality after coronary artery bypass surgery. *J Am*
5948 *Coll Cardiol* 2004;**43**:742-748.
- 5949 958. Phan K, Ha HS, Phan S, Medi C, Thomas SP, Yan TD. New-onset atrial fibrillation following
5950 coronary bypass surgery predicts long-term mortality: a systematic review and meta-analysis. *Eur J*
5951 *Cardiothorac Surg* 2015;**48**:817-824.
- 5952 959. El-Chami MF, Kilgo P, Thourani V, Lattouf OM, Delurgio DB, Guyton RA, Leon AR, Puskas
5953 JD. New-onset atrial fibrillation predicts long-term mortality after coronary artery bypass graft. *J Am*
5954 *Coll Cardiol* 2010;**55**:1370-1376.
- 5955 960. Anderson E, Dyke C, Levy JH. Anticoagulation strategies for the management of
5956 postoperative atrial fibrillation. *Clin Lab Med* 2014;**34**:537-561.
- 5957 961. Haldal M, Atar D. Pharmacological conversion of recent-onset atrial fibrillation: a systematic
5958 review. *Scand Cardiovasc J Suppl* 2013;**47**:2-10.
- 5959 962. Gillinov AM, Bagiella E, Moskowitz AJ, Raiten JM, Groh MA, Bowdish ME, Ailawadi G,
5960 Kirkwood KA, Perrault LP, Parides MK, Smith II RL, Kern JA, Dussault G, Hackmann AE, Jeffries NO,
5961 Miller MA, Taddei-Peters WC, Rose EA, Weisel RD, Williams DL, Mangusan RF, Argenziano M,
5962 Moquete EG, O'Sullivan KL, Pellerin M, Shah KJ, Gammie JS, Mayer ML, Voisine P, Gelijns AC,
5963 O'Gara PT, Mack MJ, CTSN. Rate Control versus Rhythm Control for Atrial Fibrillation after Cardiac
5964 Surgery. *N Engl J Med* 2016:[Epub ahead of print].
- 5965 963. Triedman JK. Arrhythmias in adults with congenital heart disease. *Heart* 2002;**87**:383-389.
- 5966 964. Ammash NM, Phillips SD, Hodge DO, Connolly HM, Grogan MA, Friedman PA, Warnes CA,
5967 Asirvatham SJ. Outcome of direct current cardioversion for atrial arrhythmias in adults with congenital
5968 heart disease. *Int J Cardiol* 2012;**154**:270-274.
- 5969 965. Greason KL, Dearani JA, Theodoro DA, Porter CB, Warnes CA, Danielson GK. Surgical
5970 management of atrial tachyarrhythmias associated with congenital cardiac anomalies: Mayo Clinic
5971 experience. *Semin Thorac Cardiovasc Surg Pediatr Card Surg Annu* 2003;**6**:59-71.
- 5972 966. Payne L, Zeigler VL, Gillette PC. Acute cardiac arrhythmias following surgery for congenital
5973 heart disease: mechanisms, diagnostic tools, and management. *Crit Care Nurs Clin North Am*
5974 2011;**23**:255-272.
- 5975 967. Koyak Z, Harris L, de Groot JR, Silversides CK, Oechslin EN, Bouma BJ, Budts W,
5976 Zwinderman AH, Van Gelder IC, Mulder BJ. Sudden cardiac death in adult congenital heart disease.
5977 *Circulation* 2012;**126**:1944-1954.
- 5978 968. Jensen AS, Idorn L, Norager B, Vejlstrup N, Sondergaard L. Anticoagulation in adults with
5979 congenital heart disease: The who, the when and the how? *Heart* 2014.
- 5980 969. Fujita S, Takahashi K, Takeuchi D, Manaka T, Shoda M, Hagiwara N, Kurosawa H, Nakanishi
5981 T. Management of late atrial tachyarrhythmia long after Fontan operation. *J Cardiol* 2009;**53**:410-416.
- 5982 970. Feltes TF, Friedman RA. Transesophageal echocardiographic detection of atrial thrombi in
5983 patients with nonfibrillation atrial tachyarrhythmias and congenital heart disease. *J Am Coll Cardiol*
5984 1994;**24**:1365-1370.

- 5985 971. Nagao K, Tsuchihashi K, Tanaka S, Iimura O. [Studies on atrial arrhythmias in atrial septal
5986 defect. The influences of aging on atrial fibrillation]. *Nihon Ronen Igakkai Zasshi* 1995;**32**:27-32.
- 5987 972. Giamberti A, Chessa M, Abella R, Butera G, Negura D, Foresti S, Carminati M, Cappato R,
5988 Frigiola A. Surgical treatment of arrhythmias in adults with congenital heart defects. *Int J Cardiol*
5989 2008;**129**:37-41.
- 5990 973. Roos-Hesselink JW, Meijboom FJ, Spitaels SE, van Domburg R, van Rijen EH, Utens EM,
5991 Bogers AJ, Simoons ML. Excellent survival and low incidence of arrhythmias, stroke and heart failure
5992 long-term after surgical ASD closure at young age. A prospective follow-up study of 21-33 years. *Eur*
5993 *Heart J* 2003;**24**:190-197.
- 5994 974. Yamada T, McElderry HT, Muto M, Murakami Y, Kay GN. Pulmonary vein isolation in patients
5995 with paroxysmal atrial fibrillation after direct suture closure of congenital atrial septal defect. *Circ J*
5996 2007;**71**:1989-1992.
- 5997 975. Van De Bruaene A, Delcroix M, Pasquet A, De Backer J, Paelinck B, Morissens M, Budts W.
5998 The importance of pulmonary artery pressures on late atrial arrhythmia in transcatheter and surgically
5999 closed ASD type secundum. *Int J Cardiol* 2011;**152**:192-195.
- 6000 976. de Salle P, Goenen M, Lecron J, Jaumin P, Tremouroux J. [Rhythm disorders occurring after
6001 surgical closure of the interatrial communication]. *Acta Cardiol* 1975;**30**:239-249.
- 6002 977. Scaglione M, Caponi D, Ebrille E, Di Donna P, Di Clemente F, Battaglia A, Raimondo C,
6003 Appendino M, Gaita F. Very long-term results of electroanatomic-guided radiofrequency ablation of
6004 atrial arrhythmias in patients with surgically corrected atrial septal defect. *Europace* 2014;**16**:1800-
6005 1807.
- 6006 978. Kanter RJ, Garson A, Jr. Atrial arrhythmias during chronic follow-up of surgery for complex
6007 congenital heart disease. *Pacing Clin Electrophysiol* 1997;**20**:502-511.
- 6008 979. Porter CJ, Garson A. Incidence and management of dysrhythmias after Fontan procedure.
6009 *Herz* 1993;**18**:318-327.
- 6010 980. Gelatt M, Hamilton RM, McCrindle BW, Gow RM, Williams WG, Trusler GA, Freedom RM.
6011 Risk factors for atrial tachyarrhythmias after the Fontan operation. *J Am Coll Cardiol* 1994;**24**:1735-
6012 1741.
- 6013 981. Peters NS, Somerville J. Arrhythmias after the Fontan procedure. *Br Heart J* 1992;**68**:199-
6014 204.
- 6015 982. Kwak JG, Kim WH, Lee JR, Kim YJ. Surgical therapy of arrhythmias in single-ventricle
6016 patients undergoing Fontan or Fontan conversion. *J Card Surg* 2009;**24**:738-741.
- 6017 983. Backer CL, Tsao S, Deal BJ, Mavroudis C. Maze procedure in single ventricle patients. *Semin*
6018 *Thorac Cardiovasc Surg Pediatr Card Surg Annu* 2008:44-48.
- 6019 984. Deal BJ, Mavroudis C, Backer CL. The role of concomitant arrhythmia surgery in patients
6020 undergoing repair of congenital heart disease. *Pacing Clin Electrophysiol* 2008;**31 Suppl 1**:S13-16.
- 6021 985. Gandhi SK. Atrial arrhythmia surgery in congenital heart disease. *J Interv Card Electrophysiol*
6022 2007;**20**:119-125.
- 6023 986. Correa R, Sherwin ED, Kovach J, Mah DY, Alexander ME, Cecchin F, Walsh EP, Triedman
6024 JK, Abrams DJ. Mechanism and ablation of arrhythmia following total cavopulmonary connection. *Circ*
6025 *Arrhythm Electrophysiol* 2015;**8**:318-325.
- 6026 987. Khairy P, Aboulhosn J, Gurvitz MZ, Opatowsky AR, Mongeon FP, Kay J, Valente AM, Earing
6027 MG, Lui G, Gersony DR, Cook S, Ting JG, Nickolaus MJ, Webb G, Landzberg MJ, Broberg CS,
6028 Alliance for Adult Research in Congenital Cardiology. Arrhythmia burden in adults with surgically
6029 repaired tetralogy of Fallot: a multi-institutional study. *Circulation* 2010;**122**:868-875.
- 6030 988. Kobayashi J, Yamamoto F, Nakano K, Sasako Y, Kitamura S, Kosakai Y. Maze procedure for
6031 atrial fibrillation associated with atrial septal defect. *Circulation* 1998;**98**:II399-402.
- 6032 989. Shim H, Yang JH, Park PW, Jeong DS, Jun TG. Efficacy of the maze procedure for atrial
6033 fibrillation associated with atrial septal defect. *Korean J Thorac Cardiovasc Surg* 2013;**46**:98-103.
- 6034 990. Gutierrez SD, Earing MG, Singh AK, Tweddell JS, Bartz PJ. Atrial tachyarrhythmias and the
6035 Cox-maze procedure in congenital heart disease. *Congenit Heart Dis* 2013;**8**:434-439.
- 6036 991. Sherwin ED, Triedman JK, Walsh EP. Update on interventional electrophysiology in
6037 congenital heart disease: evolving solutions for complex hearts. *Circ Arrhythm Electrophysiol*
6038 2013;**6**:1032-1040.
- 6039 992. Wellens HJ. Contemporary management of atrial flutter. *Circulation* 2002;**106**:649-652.
- 6040 993. Bertaglia E, Zoppo F, Bonso A, Proclemer A, Verlato R, Coro L, Mantovan R, D'Este D, Zerbo
6041 F, Pascotto P. Long term follow up of radiofrequency catheter ablation of atrial flutter: clinical course
6042 and predictors of atrial fibrillation occurrence. *Heart* 2004;**90**:59-63.

- 6043 994. Seara JG, Roubin SR, Gude Sampedro F, Barreiro VB, Sande JM, Manero MR, Grandio PC,
6044 Alvarez B, Juanatey JG. Risk of atrial fibrillation, stroke, and death after radiofrequency catheter
6045 ablation of typical atrial flutter. *Clin Res Cardiol* 2014;**103**:543-552.
- 6046 995. Brembilla-Perrot B, Girerd N, Sellal JM, Olivier A, Manenti V, Villemin T, Beurrier D, de
6047 Chillou C, Louis P, Selton O, de la Chaise AT. Risk of atrial fibrillation after atrial flutter ablation:
6048 impact of AF history, gender, and antiarrhythmic drug medication. *J Cardiovasc Electrophysiol*
6049 2014;**25**:813-820.
- 6050 996. Bronis K, Metaxa S, Koulouris S, Manolis AS. Vernakalant: review of a novel atrial selective
6051 antiarrhythmic agent and its place in current treatment of atrial fibrillation. *Hosp Chronicles*
6052 2012;**7**:171-181.
- 6053 997. Nair M, George LK, Koshy SK. Safety and efficacy of ibutilide in cardioversion of atrial flutter
6054 and fibrillation. *J Am Board Fam Med* 2011;**24**:86-92.
- 6055 998. Reisinger J, Gstrein C, Winter T, Zeindlhofer E, Hollinger K, Mori M, Schiller A, Winter A,
6056 Geiger H, Siostrzonek P. Optimization of initial energy for cardioversion of atrial tachyarrhythmias with
6057 biphasic shocks. *Am J Emerg Med* 2010;**28**:159-165.
- 6058 999. Pinski SL, Sgarbossa EB, Ching E, Trohman RG. A comparison of 50-J versus 100-J shocks
6059 for direct-current cardioversion of atrial flutter. *Am Heart J* 1999;**137**:439-442.
- 6060 1000. Manolis AS, Dragazis I, Kapelakis I, Papadimitriou P, Sakellaris N. Transesophageal
6061 overdrive pacing: A simple and versatile tool. *Hosp Chronicles* 2013;**8**:143-145.
- 6062 1001. Poulidakis E, Manolis AS. Transvenous temporary cardiac pacing. *Rhythmos* 2014;**9**:20-27.
- 6063 1002. Spector P, Reynolds MR, Calkins H, Sondhi M, Xu Y, Martin A, Williams CJ, Sledge I. Meta-
6064 analysis of ablation of atrial flutter and supraventricular tachycardia. *Am J Cardiol* 2009;**104**:671-677.
- 6065 1003. Schmieder S, Ndrepepa G, Dong J, Zrenner B, Schreieck J, Schneider MA, Karch MR,
6066 Schmitt C. Acute and long-term results of radiofrequency ablation of common atrial flutter and the
6067 influence of the right atrial isthmus ablation on the occurrence of atrial fibrillation. *Eur Heart J*
6068 2003;**24**:956-962.
- 6069 1004. Bandini A, Golia P, Caroli E, Biancoli S, Galvani M. Atrial fibrillation after typical atrial flutter
6070 ablation: a long-term follow-up. *J Cardiovasc Med (Hagerstown)* 2011;**12**:110-115.
- 6071 1005. Dewland TA, Glidden DV, Marcus GM. Healthcare utilization and clinical outcomes after
6072 catheter ablation of atrial flutter. *PLoS One* 2014;**9**:e100509.
- 6073 1006. Esato M, Hindricks G, Sommer P, Arya A, Gaspar T, Bode K, Bollmann A, Wetzel U, Hilbert
6074 S, Kircher S, Eitel C, Piorkowski C. Color-coded three-dimensional entrainment mapping for analysis
6075 and treatment of atrial macroreentrant tachycardia. *Heart Rhythm* 2009;**6**:349-358.
- 6076 1007. Huo Y, Schoenbauer R, Richter S, Rolf S, Sommer P, Arya A, Rastan A, Doll N, Mohr FW,
6077 Hindricks G, Piorkowski C, Gaspar T. Atrial Arrhythmias Following Surgical AF Ablation:
6078 Electrophysiological Findings, Ablation Strategies, and Clinical Outcome. *J Cardiovasc Electrophysiol*
6079 2014;**25**:725-738.
- 6080 1008. Institute of Medicine Committee on Quality of Health Care in America. *Crossing the Quality*
6081 *Chasm: A New Health System for the 21st Century*. Washington (DC): National Academies Press
6082 (US); 2001.
- 6083 1009. Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic
6084 illness. *JAMA* 2002;**288**:1775-1779.
- 6085 1010. Hibbard JH, Greene J. What the evidence shows about patient activation: better health
6086 outcomes and care experiences; fewer data on costs. *Health Aff (Millwood)* 2013;**32**:207-214.
- 6087 1011. McCabe PJ. Self-management of atrial fibrillation: a new frontier for nursing research. *Prog*
6088 *Cardiovasc Nurs* 2008;**23**:37-40.
- 6089 1012. Lip GY, Kamath S, Jafri M, Mohammed A, Bareford D. Ethnic differences in patient
6090 perceptions of atrial fibrillation and anticoagulation therapy: the West Birmingham Atrial Fibrillation
6091 Project. *Stroke* 2002;**33**:238-242.
- 6092 1013. Clarkesmith DE, Pattison HM, Lane DA. Educational and behavioural interventions for
6093 anticoagulant therapy in patients with atrial fibrillation. *Cochrane Database Syst Rev*
6094 2013;**6**:Cd008600.
- 6095 1014. Clarkesmith DE, Pattison HM, Lip GY, Lane DA. Educational intervention improves
6096 anticoagulation control in atrial fibrillation patients: the TREAT randomised trial. *PLoS One*
6097 2013;**8**:e74037.
- 6098 1015. Smith DE, Xuereb CB, Pattison HM, Lip GY, Lane DA. TRial of an Educational intervention on
6099 patients' knowledge of Atrial fibrillation and anticoagulant therapy, INR control, and outcome of
6100 Treatment with warfarin (TREAT). *BMC Cardiovasc Disord* 2010;**10**:21.
- 6101 1016. Smith MB, Christensen N, Wang S, Strohecker J, Day JD, Weiss JP, Crandall BG, Osborn
6102 JS, Anderson JL, Horne BD, Muhlestein JB, Lappe DL, Moss H, Oliver J, Viau K, Bunch TJ. Warfarin

- 6103 knowledge in patients with atrial fibrillation: implications for safety, efficacy, and education strategies.
6104 *Cardiology* 2010;**116**:61-69.
- 6105 1017. Aliot E, Breithardt G, Brugada J, Camm J, Lip GY, Vardas PE, Wagner M, Atrial Fibrillation
6106 AWareness and Risk Education group [comprising the Atrial Fibrillation Association (AFA), the
6107 European Heart Rhythm Association (EHRA), Stroke Alliance for Europe (SAFE), and the World Heart
6108 Federation (WHF)]. An international survey of physician and patient understanding, perception, and
6109 attitudes to atrial fibrillation and its contribution to cardiovascular disease morbidity and mortality.
6110 *Europace* 2010;**12**:626-633.
- 6111 1018. Hendriks JM, Crijns HJ, Tieleman RG, Vrijhoef HJ. The atrial fibrillation knowledge scale:
6112 development, validation and results. *Int J Cardiol* 2013;**168**:1422-1428.
- 6113 1019. McCabe PJ. What patients want and need to know about atrial fibrillation. *J Multidiscip*
6114 *Healthc* 2011;**4**:413-419.
- 6115 1020. Lorig KR, Holman H. Self-management education: history, definition, outcomes, and
6116 mechanisms. *Ann Behav Med* 2003;**26**:1-7.
- 6117 1021. Stiggelbout AM, Van der Weijden T, De Wit MP, Frosch D, Legare F, Montori VM, Trevena L,
6118 Elwyn G. Shared decision making: really putting patients at the centre of healthcare. *BMJ*
6119 2012;**344**:e256.
- 6120 1022. Stacey D, Legare F, Col NF, Bennett CL, Barry MJ, Eden KB, Holmes-Rovner M, Llewellyn-
6121 Thomas H, Lyddiatt A, Thomson R, Trevena L, Wu JH. Decision aids for people facing health
6122 treatment or screening decisions. *Cochrane Database Syst Rev* 2014;**1**:CD001431.
- 6123 1023. Elwyn G, Frosch D, Thomson R, Joseph-Williams N, Lloyd A, Kinnersley P, Cording E,
6124 Tomson D, Dodd C, Rollnick S, Edwards A, Barry M. Shared decision making: a model for clinical
6125 practice. *J Gen Intern Med* 2012;**27**:1361-1367.
- 6126 1024. Van Wagoner DR, Piccini JP, Albert CM, Anderson ME, Benjamin EJ, Brundel B, Califf RM,
6127 Calkins H, Chen PS, Chiamvimonvat N, Darbar D, Eckhardt LL, Ellinor PT, Exner DV, Fogel RI, Gillis
6128 AM, Healey J, Hohnloser SH, Kamel H, Lathrop DA, Lip GY, Mehra R, Narayan SM, Olgin J, Packer
6129 D, Peters NS, Roden DM, Ross HM, Sheldon R, Wehrens XH. Progress toward the prevention and
6130 treatment of atrial fibrillation: A summary of the Heart Rhythm Society Research Forum on the
6131 Treatment and Prevention of Atrial Fibrillation, Washington, DC, December 9-10, 2013. *Heart Rhythm*
6132 2015;**12**:e5-e29.
- 6133 1025. van Nieuwenhuizen KM, van der Worp HB, Algra A, Kappelle LJ, Rinkel GJ, van Gelder IC,
6134 Schutgens RE, Klijn CJ, APACHE-AF Investigators. Apixaban versus Antiplatelet drugs or no
6135 antithrombotic drugs after anticoagulation-associated intraCerebral HaEmorrhage in patients with
6136 Atrial Fibrillation (APACHE-AF): study protocol for a randomised controlled trial. *Trials* 2015;**16**:393.
- 6137 1026. Gronberg T, Nuotio I, Nikkinen M, Ylitalo A, Vasankari T, Hartikainen JE, Airaksinen KE.
6138 Arrhythmic complications after electrical cardioversion of acute atrial fibrillation: the FinCV study.
6139 *Europace* 2013;**15**:1432-1435.
- 6140 1027. Tse HF, Lau CP. Does sinus rhythm beget sinus rhythm? Effects of prompt cardioversion on
6141 the frequency and persistence of recurrent atrial fibrillation. *Card Electrophysiol Rev* 2003;**7**:359-365.
- 6142 1028. Van Gelder IC, Hemels ME. The progressive nature of atrial fibrillation: a rationale for early
6143 restoration and maintenance of sinus rhythm. *Europace* 2006;**8**:943-949.
- 6144 1029. Liu ZJ, Fu WG, Guo ZY, Shen LG, Shi ZY, Li JH. Updated systematic review and meta-
6145 analysis of randomized clinical trials comparing carotid artery stenting and carotid endarterectomy in
6146 the treatment of carotid stenosis. *Ann Vasc Surg* 2012;**26**:576-590.
- 6147 1030. Taylor DW, Barnett HJM, Haynes RB, Ferguson GG, Sackett DL, Thorpe KE, Simard D,
6148 Silver FL, Hachinski V, Clagett GP, barnes R, Spence JD, ASA and Carotid Endarterectomy (ACE)
6149 trial collaborators. Low-dose and high-dose acetylsalicylic acid for patients undergoing carotid
6150 endarterectomy: a randomised controlled trial. *Lancet* 1999;**353**:2179-2184.
- 6151 1031. Watanabe M, Chaudhry SA, Adil MM, Alqadri SL, Majidi S, Semaan E, Qureshi AI. The effect
6152 of atrial fibrillation on outcomes in patients undergoing carotid endarterectomy or stent placement in
6153 general practice. *J Vasc Surg* 2015;**61**:927-932.
- 6154 1032. Breithardt G, Baumgartner H, Berkowitz SD, Hellkamp AS, Piccini JP, Stevens SR,
6155 Lokhnygina Y, Patel MR, Halperin JL, Singer DE, Hankey GJ, Hacke W, Becker RC, Nessel CC,
6156 Mahaffey KW, Fox KA, Califf RM, ROCHET AF Steering Committee & Investigators. Clinical
6157 characteristics and outcomes with rivaroxaban vs. warfarin in patients with non-valvular atrial
6158 fibrillation but underlying native mitral and aortic valve disease participating in the ROCKET AF trial.
6159 *Eur Heart J* 2014;**35**:3377-3385.
- 6160 1033. Philippart R, Brunet-Bernard A, Clementy N, Bourguignon T, Mirza A, Babuty D, Angoulvant
6161 D, Lip GY, Fauchier L. Prognostic value of CHA2DS2-VASc score in patients with 'non-valvular atrial

- 6162 fibrillation' and valvular heart disease: the Loire Valley Atrial Fibrillation Project. *Eur Heart J*
6163 2015;**36**:1822-1830.
- 6164 1034. Breithardt G, Baumgartner H. Valvular heart disease among non-valvular atrial fibrillation: a
6165 misnomer, in search of a new term. *Eur Heart J* 2015;**36**:1794-1797.
- 6166 1035. Wolf RK, Schneeberger EW, Osterday R, Miller D, Merrill W, Flege JB, Jr., Gillinov AM.
6167 Video-assisted bilateral pulmonary vein isolation and left atrial appendage exclusion for atrial
6168 fibrillation. *J Thorac Cardiovasc Surg* 2005;**130**:797-802.
- 6169 1036. Yilmaz A, Van Putte BP, Van Boven WJ. Completely thoracoscopic bilateral pulmonary vein
6170 isolation and left atrial appendage exclusion for atrial fibrillation. *J Thorac Cardiovasc Surg*
6171 2008;**136**:521-522.
- 6172 1037. Salzberg SP, Plass A, Emmert MY, Desbiolles L, Alkadhi H, Grunenfelder J, Genoni M. Left
6173 atrial appendage clip occlusion: early clinical results. *J Thorac Cardiovasc Surg* 2010;**139**:1269-1274.
- 6174 1038. Papworth Hospital NHS Foundation Trust. *A randomised controlled trial to investigate the*
6175 *clinical and cost effectiveness of adding an ablation device-based maze procedure as a routine*
6176 *adjunct to elective cardiac surgery for patients with pre-existing atrial fibrillation.*
6177 <http://www.isrctn.com/ISRCTN82731440>. Date last accessed 5 May 2016 ISRCTN82731440
- 6178 1039. Efficacy and safety of ablation for patients with non-paroxysmal atrial fibrillation. doi:
6179 10.1002/14651858.CD012088.pub2
- 6180 1040. Concomitant atrial fibrillation surgery for people undergoing cardiac surgery. doi:
6181 10.1002/14651858.CD011814.pub2
- 6182 1041. Hemingway CPRD data (when published)
- 6183 1042. MANTRA-PAF 5 yr outcomes (when published)