Atrial Fibrillation

Comprehensive care, stroke prevention, rate/rhythm control, catheter ablation, and AF with heart failure for adults with AF.

2023 ACC/AHA/ACCP/HRS
Atrial Fibrillation Guideline
Joglar et al. · JACC 2024;83:109–279

COR — I · Recommended | IIa · Reasonable | IIb · May Consider | III · No Benefit / Harm

1 Comprehensive Care & Risk Factor Modification

I (A) — **Team-based care** — all AF patients: comprehensive care addressing LRFM, symptoms, stroke risk, comorbidities.

IIa — **Care pathways** — nurse-led AF clinics reasonable to enhance adherence to evidence-based therapy.

Targets — **Modifiable drivers** — weight loss ≥10%, no alcohol, OSA screen/Rx, exercise, BP & glycemic control.

2 Stroke Risk Stratification & Anticoagulation Selection

CHA_2DS_2-VASC	PTS
CHF / LV dysfunction	1
Hypertension	1
Age ≥75y	2
Diabetes	1
Stroke/TIA/TE	2
Vascular disease	1
Age 65–74y	1
Sex (female)	1

I (A) — **Threshold to anticoagulate** — annual risk ≥2% (score ≥2 men / ≥3 women): anticoagulation recommended, regardless of AF pattern.

I (A) — **DOAC over warfarin** — unless mod–severe rheumatic MS or mechanical valve. Bleeding scores never justify withholding OAC alone; reassess ≥annually.

3 Rate vs. Rhythm Control

I (B-NR) — **Shared decision-making** — discuss rate- vs. rhythm-control considering presentation, comorbidity, meds, preference. HR goal <100–110 bpm (no HF) reasonable (IIa).

COR	ACUTE RATE CONTROL AGENT	NOTES
I · B-R	Beta-blocker or non-DHP CCB	First line, stable, EF>40%
IIa	Digoxin ± IV magnesium	If BB/CCB ineffective; or as adjunct
III · Harm	IV non-DHP CCB	Avoid if mod–severe LV dysfunction ± decompensated HF

4 Cardioversion & Periprocedural Anticoagulation

I — **AF ≥48h/unknown duration** — 3wk uninterrupted OAC or TEE before elective cardioversion → **peri-cardioversion:** OAC established before, continued ≥4wk after, uninterrupted → **thrombus on imaging:** defer; anticoagulate 3–6wk, re-image before proceeding.

ANTICOAGULANT (INVASIVE PROCEDURE)	LOW BLEEDING RISK	HIGH BLEEDING RISK
DOAC (apixaban/dabigatran/edoxaban/rivaroxaban)	Hold 1d	Hold 2d
Warfarin	Hold ~5d (INR<1.5)	Hold ~5d

III (Harm) — No LMWH bridging when holding warfarin (except mechanical valve/recent stroke-TIA). Resume DOAC POD1 (low-risk) – POD2–3 evening (high-risk) once hemostasis secure.

5 Long-Term Rhythm Control: Antiarrhythmic Selection

DRUG (COR)	BEST-FIT POPULATION	KEY CAUTION
IIa Flecainide/propafenone	No prior MI/structural or ischemic heart disease	Avoid with scar, CAD, reduced EF
IIa Dronedarone	No recent decompensated HF/severe LV dysfxn	Contraindicated NYHA III–IV / decompensated HF <4wk (III)
IIa Dofetilide	Structural heart disease incl. HFrEF	Renal-dosed; monitor QT, K^+, Mg^{2+}
IIa Amiodarone (low-dose)	HFrEF or when other options fail	Reserve for refractory — organ toxicity

6 Catheter Ablation & LAA Management

I (A) — **Ablation, after failed AAD** — useful when antiarrhythmics ineffective/not tolerated/preferred.

I (A) — **Ablation, first-line** — younger, few comorbidities, symptomatic paroxysmal AF; also AF+HFrEF on GDMT.

IIa — **Percutaneous LAAO** — CHA_2DS_2-VASc ≥2 + nonreversible OAC contraindication.

IIb — **LAAO vs. OAC** — high bleeding risk: reasonable alternative per preference; OAC evidence larger.

7 AF & Heart Failure

I (B-NR) — **Suspect tachycardiomyopathy** — new HFrEF+AF: pursue early, aggressive rhythm control.

IIa — **AVNA + BiV pacing** — refractory rapid response in HFrEF, not candidate for/failed rhythm control.

III (Harm) — **Avoid in HFrEF** — non-DHP CCBs, LVEF<40%; dronedarone in NYHA III–IV/recent decompensated HF.

Remember — Stroke risk (not AF pattern) drives the anticoagulation decision, and it's never "finished": reassess CHA_2DS_2-VASc, bleeding risk, and dosing at least annually. Bleeding-risk tools flag modifiable factors — never use them alone to withhold indicated anticoagulation.

Joglar JA, Chung MK, Armbruster AL, et al. 2023 ACC/AHA/ACCP/HRS Guideline for the Diagnosis and Management of Atrial Fibrillation. *J Am Coll Cardiol.* 2024;83(2):109–279.