Liječenje fibrilacije atrijske u bolesnika s resinkronizacijskom terapijom srca

Management of atrial fibrillation in patients with cardiac resynchronization therapy

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S obzirom na klinički profil, fibrilacija atrijske (FA) je često prisutna u bolesnika s resinkronizacijskom terapijom srca (CRT) i može imati značajan negativan utjecaj na prognozu i klinički odgovor na CRT. Liječenje FA u CRT bolesnika je slojevito, a uključuje optimalnu medikamentu terapiju za zatajivanje srca (ZS), antikoagulantnu terapiju i strategiju za kontrolu frekvencije ili kontrolu ritma.¹⁻³

U bolesnika sa ZS i FA, kontrola ritma s antiaritmicijskim lijekovima (AALs) nije uspjela pokazati ikakvu dobit u preživljavanju u usporedbi sa strategijom kontrole frekvencije. U tom kontekstu, kontrola frekvencije lijekovima (betablokatori ili/ digoxin) se preferirala kao prvi izbor liječenja u CRT bolesnika s perzistentnom/trajnom FA. Međutim, većina opservacijskih CRT studija i meta-analiza pokazuje da je ablacija AV spoja (AAVS) superiorna lijekovima za kontrolu frekvencije u postizanju adekvatne biventrikularne stimulacije (BiVS) i smanjenju smrtnosti. Amiodaron i dofetilid su jedini AALs, koji se u smjernicama preporučuju za kontrolu ritma u bolesnika sa ZS. Međutim, ovi lijekovi imaju umjerenu učinkovitost i značajne nuspojave, uključujući i proaritmiju. Zbog toga je upotreba kateterske ablacije FA (KAFA) za kontrolu ritma proširena na bolesnike s kroničnim ZS. U nedavnoj meta-analizi 16 opservacijskih studija s 1253 bolesnika, sveukupni uspjeh KAFA bio je 77 % s poboljšanjem ejekcijske frakcije (EF) od 13 %. Četiri male randomizirane studije, koje su uspoređivale KAFA s kontrolom frekvencije u bolesnika sa ZS i perzistentnom FA, pokazale su značajno poboljšanje EF, kvalitete života i funkcionalne sposobnosti s KAFA. U randomiziranoj studiji, koja je uključila 203 bolesnika s perzistentnom FA, ZS, EF < 40% i implantiranim ICD/CRT-D, KAFA je bila superiorna amiodaronu u postizanju prevencije FA (70 prema 34 %, p<0.001), smanjenju hospitalizacije (31 prema 38 %, p<0.001) i smanjenju smrtnosti (8 prema 18 %, p=0.037).

Kritički cilj liječenja FA u CRT bolesnika je osigurati visok postotak BiVS (> 98 %). U tom smislu, strategija kontrole frekvencije ostaje prvi terapijski izbor za CRT bolesnike s trajnom FA. KAFA treba razmotriti u CRT bolesnika s paroksizmalnom FA, koji ne reagiraju na AALs, i u odabranih bolesnika s perzistentnom FA prije prihvaćanja strategije za kontrolu frekvencije.

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With regard to clinical profile, atrial fibrillation (AF) is often present in patients with cardiac resynchronization therapy and can have a significant negative impact on the prognosis and clinical response to CRT. Management of AF in patients with CRT is multilevel and includes optimal medical heart failure (HF) therapy, anticoagulant therapy, and rate or rhythm control strategy.¹⁻³

In patients with HF and AF, rhythm control with antiarrhythmic drugs (AADs) has failed to show any survival benefit compared with a rate control strategy. In this context, a rate control with drugs (beta-blockers or/and digoxin) was preferred as first-line therapy in CRT patients with persistent/permanent AF. However, the most observational CRT studies and meta-analyses indicate that AV junction ablation (AVJA) is superior to rate control drugs in achieving adequate biventricular pacing (BVP) and reducing mortality. Amiodaron and dofetilide are the lone guideline-recommended AADs for rhythm control in HF patients, but they have a moderate efficacy and significant side effects, including proarrhythmia. Because of that the use of AF catheter ablation (AFCA) for a rhythm control is extended to patients with chronic HF. In recent meta-analysis of 16 observational studies with 1253 patients, overall success rate of AFCA in patients with LV dysfunction was 77% with consequent improvement in EF of 13%. Four small randomized studies that compared AFCA with a rate control in HF patients with persistent AF showed a significant improvement in EF, quality of life and functional capacity with AFCA. In randomized study that included 203 pts with persistent AF, HF, EF<40% and implanted ICD/CRT-D, AFCA was superior to amiodaron in achieving freedom from AF (70 versus 34%, p<0.001) and reducing hospitalization (31 versus 38%, p<0.001) and mortality (8 versus 18%, p=0.037).

The critical goal of AF management in CRT patients is to ensure a high percentage of BiVS (>98%). In this context, rate control strategy remains the first therapeutic option for CRT pts with permanent AF. AFCA should be considered in CRT patients with paroxysmal AF who are non-responders to AADs, and in selected patients with persistent AF prior to accepting a rate control strategy.

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