Da li je oralna antikoagulantna terapija potrebna nakon svake ablacije fibrilacije atrijske? Retrospektivna pilot studija

Is oral anticoagulant therapy required after every ablation of atrial fibrillation? A retrospective pilot study

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Uvod: Ablacija fibrilacije atrijske (FA) krienergijom održava očuvani ekstracelularni matriks i endotel lijevog atrijske te se čini manje trombogenom od radiofrekventne energije¹. Trenutno se u smjernicama još uvijek preporučuje antikoagulantna terapija (OAC) minimalno 8 tjedana nakon ablacije FA². Ne postoje objavljeni podaci o sigurnosti acetylsalicylate kiseline (ASA) kao jedinog antitrombotičnog lijeka nakon kriozolacije plućnih vena.

Pacijenti i metode: Učinjena je retrospektivna analiza bolesnika s paroksizmalnom fibrilacijom atrijske kod kojih je učinjena izolacija plućnih vena (PVI) kriobalonom druge generacije (CB-A) u našoj ustanovi. Svi bolesnici imali su „CHADS-VASc score“ 0 i praćeni su minimalno 3 mjeseca nakon zahvata. Ni jedan bolesnik prije ablacije nije uzimao OAC, a postproceduralno uvođenje oralnih antikoagulanasa, odnosno ASA ostavljeno je na diskreciju operatera. Sama procedura kriozolacije vena provedena je u lokalnoj anesteziji uz sedaciju kako je prije opisano³.

Rezultati: Ukupno je analizirano 16 bolesnika (15 muškaraca, prosječna dob 51,2 ± 9,8) koji su zadovoljili uključne kriterije. Osam (50 %) od njih nakon intervencije nije primao OAC (ASA grupa), dok je druga polovica bila na novim antikoagulantima (5; 31,2%) ili antagonistima vitamina K (3; 18,8%) (OAC grupa). Dvije grupe nisu se razlikovale prema relevantnim kliničkim i proceduralnim karakteristikama. U obje grupe nisu zabilježeni ni tromboembolijski, ni hemoragijski događaji peri- i postproceduralno. Od drugih komplikacija, zabilježena je samo 1 trajna i jedna prolazna pareza frenikusa u OAC grupi (12,5 %). U promatranom razdoblju praćenja (7,7 ± 3,3 mjeseci) 2 bolesnika (12,5%) imala su recidiv aritmije nakon „blanking“ perioda (oba u ASA grupi).

Zaključak: Antikoagulantna terapija preporučuje se univerzalno nakon PVI, no osim protekcije od tromboembolijskih događaja, ona povećava rizik od krvarenja (najčešće lokalne vaskularne komplikacije). Ova mala pilot studija ukazuje da bi se navedene hemoragijske komplikacije mogle izbjeći bez kompromitiranja sigurnosti u bolesnika s niskim bazičnim tromboembolijskim rizikom prilikom korištenja kriobalona druge generacije. Potrebne su veće studije da bi se potvrdila navedena zapažanja.

Introduction: Ablation of atrial fibrillation (AF) by cryoenergy preserves intact extracellular matrix and the endothelium of the left atrium and appears to be less thrombogenic than radiofrequency energy¹. Current guidelines recommend anticoagulant therapy (OAC) for a minimum of 8 weeks after ablation of AF². There are no published data on the safety of acetylsalicylic acid (ASA) as the only antithrombotic drug after cryoballoon ablation of pulmonary veins.

Patients and Methods: We performed a retrospective analysis of patients with paroxysmal atrial fibrillation that underwent isolation of pulmonary veins (PVI) by second generation cryoballoon (CB-A) in our institution. All patients had CHADS-VASc Score 0 and were followed for a minimum of 3 months after the procedure. None of the patients before ablation were taking OAC. After the procedure, introduction of oral anticoagulants or ASA was left to the discretion of the operator. The cryoballoon procedure itself was carried out under local anesthesia with sedation as described previously³.

Results: A total of 16 patients (15 men, average age 51.2±9.8) were analyzed who met the inclusion criteria. Eight patients (50%) after the procedure did not receive OAC (ASA group), while the other half received new oral anticoagulants (5; 31.2%) or a vitamin K antagonist (3; 18.8%) (OAC group). The two groups did not differ considering the relevant clinical and procedural characteristics. In both groups, there were no thromboembolic, nor hemorrhagic events peri- and post-procedurally. Considering the other complications, we noted only one permanent and one transient phrenic nerve paresis in the OAC group (12.5%). In the mean follow-up of 7.7±3.3 months, 2 patients (12.5%) had recurrent atrial arrhythmias after „blanking“ period (both in the ASA group).

Conclusion: Anticoagulant therapy is recommended universally after PVI, but other than protection from thromboembolic events, it increases the risk of bleeding (most often local vascular complications). This small pilot study suggests that the hemorrhagic complications might be avoided without compromising the safety in patients with low basic thromboembolic risk when using second generation cryoballoon. Larger studies are needed to confirm the above findings.

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