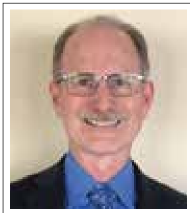

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doi: 10.12788/jfp.0367

A-fib prevention, treatment, and screening: Where does the evidence lead us?

Atrial fibrillation (AF) is a common problem confronting family physicians. In this issue of *JFP*, we offer 2 articles about AF: one on prevention and one on treatment. Both provide evidence-based guidance to help you refine your care. But gaps remain. I'll get to that in a bit.

Prevention. This month's PURL[1] discusses a randomized controlled trial (RCT) that enrolled moderate alcohol drinkers with AF.[2] Compared to those who continued to drink moderately, those who reduced their alcohol consumption to 2 drinks per week had a significant reduction in recurrent AF (73% vs 53%), fewer hospitalizations (20% vs 9%), and less moderate or severe symptoms (32% vs 10%). Although previous studies of moderate alcohol consumption have shown positive effects on heart disease, this study and other more recent studies cast serious doubt on this assertion.[3]

Treatment. In their applied evidence article, Osayande and Sharma[4] pose the question: When is catheter ablation a sound option for your patient with AF? They give us an excellent, evidence-based answer and remind us that we must focus on the treatment goals: to prevent stroke and to control symptoms. They recommend a stepwise approach, starting with rate control, progressing to rhythm control, and saving catheter ablation for resistant cases. In nearly all cases, anticoagulation to prevent stroke must be a part of treatment, with the exception of those with very low risk (so-called "lone atrial fibrillation").

Screening. And what about screening for asymptomatic AF? The US Preventive Services Task Force recently reaffirmed its conclusion that there is insufficient evidence for screening for asymptomatic AF (a topic discussed in an online Practice Alert Brief[5]).[6] Since wearable exercise-monitoring devices can detect heart arrhythmias (and are advertised for this purpose), a patient may present after receiving a notification about asymptomatic AF. What shall we do in these cases? The dilemma is that your patient will know she has a potentially dangerous condition, but there is no evidence that treating it will result in more benefit than harm.

A recently published study suggests that we should be very cautious in recommending treatment. In an RCT of patients ages 70 to 90 years, 1501 patients received an implantable loop recorder, while 4503 received routine health care; median follow-up was 64.5 months.[7] Although more cases of AF were detected (32% in the monitored group vs 12% in the usual care group), and oral anticoagulation treatment was started more frequently (30% vs 13%, respectively), there was no significant difference in the proportion of patients who had a stroke or systemic arterial embolism (4.5% vs 5.6%).[7] Until we have more data, reassurance seems to be the best recommendation for asymptomatic AF. **JFP**

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> **The dilemma is that your patient with a wearable exercise monitoring device will know she has a potentially dangerous condition, but there is no evidence that treating it will result in more benefit than harm.**

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