

Groups Issue Guidelines on Ventricular Arrhythmia

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In an attempt to pull together all the relevant data into one consensus reference guide, several prominent American and European cardiology professional organizations have issued guidelines for the diagnosis and treatment of ventricular arrhythmias and the prevention of sudden cardiac death.

The guidelines were issued by the American College of Cardiology, the American Heart Association, and the European Society of Cardiology, and were developed in collaboration with the European Heart Rhythm Association and the Heart Rhythm Society.

The joint statement consolidates at least 24 guidelines, papers, and statements, and

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incorporates evidence accumulated since publication of those various reports. It addresses acute and chronic therapies, including pharmacologic interventions, surgery and revascularization, ablation, and implanta-

tion of implantable cardioverter defibrillators (ICDs), and other devices.

"We have consciously attempted to create a streamlined document that would be useful specifically to locate recommendations on the evaluation and treatment of patients who have or may be at risk for ventricular arrhythmias," Dr. A. John Camm, European cochair of the guideline writing committee, said in a statement. "We are pleased that this consensus document has the support of all the major cardiovascular societies in Europe and the U.S."

The guidelines are "an attempt to summarize the state of knowledge and put it into usable recommendations for the practicing clinician," Dr. Robert J. Myerburg, a spokesman for the ACC and a professor of medicine and physiology at the University of Miami, said in an interview.

"There will be new information coming out which will modify the approaches recommended in this document," he said, but he added that it is unlikely that the guidelines will be updated soon as it took 3 years to pull them together. "So much effort went into it in terms of getting consensus and smoothing out the points where there were various viewpoints."

One area where varying viewpoints were brought together: recommendations for prophylactic implantable defibrillator implantation.

"The inconsistencies occurred because clinical investigators chose different ejection fractions for enrollment in trials of therapy, average values of the ejection fraction have been substantially lower than the cut-off value for enrollment, and subgroup analyses of clinical trial populations based on ejection fraction have not

been consistent in their implications," said Dr. Douglas P. Zipes, cochair of the guideline writing committee. "The result was substantial differences among guidelines."

The joint guidelines make recommendations for ejection fractions less than or equal to a range of values.

For instance, in various guidelines issued over the last few years, European and American cardiology societies had each reached somewhat different conclusions on the levels of evidence sup-

porting ICDs as primary prevention for patients with left ventricular dysfunction due to a prior myocardial infarction, New York Heart Association class II or III heart failure, and ejection fractions of 30% or less, or of 30%-35%.

The ACC/AHA/ESC guidelines reached the consensus that for all patients with left ventricular dysfunction as a result of a previous MI, there is class I, level A evidence that ICD implantation is an appropriate preventive therapy.

These are recommendations—not standards, said Dr. Myerburg, adding that cultural, financial, and societal considerations may affect how the guidelines are applied. The guidelines "take into consideration that not all therapies and recommendations are available in all segments of society" or everywhere in the world.

The guidelines' executive summary is published in the societies' journals and can be viewed online at the ACC, AHA, and ESC Web sites. ■

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