

# Is Catheter Ablation Best for Refractory Atrial Fib?

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BOSTON — Catheter ablation is superior to an assortment of antiarrhythmic drugs in the treatment of patients with paroxysmal atrial fibrillation who have previously failed at least one AAD, according to a new study.

At 1-year follow-up, success among patients undergoing ablation was 10-fold greater than in those taking antiarrhythmic drugs (AADs), at 75% and 7%, respectively. Duration of recurrent episodes of atrial fibrillation was also shorter in the ablation group (8 minutes vs. 150 minutes), as was freedom from anticoagulants (63% vs. 25%), said Dr. Pierre Jais of Hôpital Cardiologique Haut-Levêque in Bordeaux-Pessac, France.

Dr. Jais presented the results of the multicenter Atrial Fibrillation Ablation vs. Antiarrhythmic

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Drugs (A-4) trial at the annual meeting of the Heart Rhythm Society. The study was sponsored by Biosense Webster Inc., which manufactures therapeutic catheters.

The findings of the A-4 trial suggest that ablation may help people with frequent, highly symptomatic atrial fibrillation who otherwise would do poorly on AADs.

High-quality trials have yet to prove whether either of these treatments for atrial fibrillation is superior to the other. Despite the glowing near-term results of this and other studies—and the meteoric rise in the number of ablation procedures in recent years—questions remain about patient selection for ablation, outcome criteria, long-term efficacy, and safety.

Dr. Jais and colleagues randomized 112 patients from two European and two North American centers to receive lasso catheter ablation (53 patients) or treatment with one or more previously untried AADs (59 patients). The patients had experienced an average of two atrial fibrillation episodes per month over the course of at least 6 months (average duration  $9 \pm 9$  hours) and showed resistance to at least one class I or class III AAD. Their average age was 51 years; most (84%) were men. At baseline, some 80% took anticoagulants, and 21% had structural heart disease.

Clinicians were permitted to attempt as many as three interventions per patient during the first 3 months. After that, the protocol permitted failed patients to cross over to the other group. Failure was defined as atrial fibrillation lasting more than 3 minutes (self-reported or documented) at any point beyond the first 3 months.

By the 12-month follow-up mark, 84% of patients in the AAD arm had failed drug therapy, including 19 of 24 patients (79%) who had tried amiodarone for the first

time. In addition, 37 patients (63%) crossed over and underwent ablation, according to Dr. Jais. Only four patients (7%) achieved complete control of arrhythmias.

The remaining 22 chose not to undergo ablation, “presumably because they were feeling much better because of the intensification of their treatments,” said Dr. Jais. The AAD group attempted 88 class I, 39 class II, 59 class III, and 6 class IV drugs.

By contrast, three patients in four who

underwent ablation were free of arrhythmias. As in previous studies, repeat procedures were common; investigators required an average of 1.8 procedures per patient to achieve pulmonary vein isolation (155 procedures in 90 patients).

Secondary outcome measures, including quality of life and exercise duration, also favored the ablation procedure.

There was one case of amiodarone-induced hyperthyroidism in the AAD group. Significant complications in the ab-

lation group included two episodes of tamponade and one case of pulmonary vein stenosis.

In patients who failed at least one AAD, “complete arrhythmia control is really unlikely using antiarrhythmics; it’s a 7% success rate at 1 year,” said Dr. Jais.

“This includes amiodarone, where the success rate is just 21%. ... Without any doubt, further studies are now required to compare the impact of these strategies on longer-term outcomes.” ■



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