Dear Editor,

Recently, transcatheter ablation of atrial fibrillation (AF) has been validated by international societal guidelines as a technique suitable for both treatment and secondary prevention of paroxysmal, persistent or long-lasting persistent AF in highly symptomatic patients in whom at least one antiarrhythmic drug had been tested [1].

However, recently, dissonant voices have arisen. In particular, the CABANA trial [2] has outlined that AF ablation compared to simple antiarrhythmic pharmacotherapy does not result in an improvement of the composite end-point consisting of death, disabling stroke, severe bleeding and cardiac arrest, on the basis of the “intention to treat” analysis. Besides, the results of the “ESC Heart Failure Long-Term Registry”, a large (14,964 patients with heart failure) prospective cohort study published in December 2018 [3] showed that a statistically significant harm, namely more numerous data would seem to pave the way for the choice to avoid rhythm control strategy and therefore also AF ablation in HFREF patients, in whom AF is not associated with an increased risk of HF hospitalizations as well as of the composite of all-cause mortality and HF hospitalizations. However, the appropriateness of AF ablation in HFREF patients could only be assessed by randomized controlled trials (RCTs) of AF ablation versus rate control strategy in this specific subset. In any case, the above-mentioned prospective cohort study [3] can be regarded useful in outlining possible scenarios that could subsequently be explored by well-arranged RCTs. Indeed, this registry data would seem to pave the way for the choice to avoid rhythm control strategy and therefore also AF ablation in HFREF patients, aiming rather at a rate control strategy. Of course, any conclusion is premature and inappropriate, as lacking of the requisite confirmation by a RCT. On this subject, which is still controversial for many aspects, a well-reasoned and clearly articulated debate could be very useful.

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However, recently, dissonant voices have arisen. In particular, the CABANA trial [2] has outlined that AF ablation compared to simple antiarrhythmic pharmacotherapy does not result in an improvement of the composite end-point consisting of death, disabling stroke, severe bleeding and cardiac arrest, on the basis of the “intention to treat” analysis. Besides, the results of the “ESC Heart Failure Long-Term Registry”, a large (14,964 patients with heart failure) prospective cohort study published in December 2018 [3] showed that a statistically significant harm, namely more numerous data would seem to pave the way for the choice to avoid rhythm control strategy and therefore also AF ablation in HFREF patients, in whom AF is not associated with an increased risk of HF hospitalizations as well as of the composite of all-cause mortality and HF hospitalizations. However, the appropriateness of AF ablation in HFREF patients could only be assessed by randomized controlled trials (RCTs) of AF ablation versus rate control strategy in this specific subset. In any case, the above-mentioned prospective cohort study [3] can be regarded useful in outlining possible scenarios that could subsequently be explored by well-arranged RCTs. Indeed, this registry data would seem to pave the way for the choice to avoid rhythm control strategy and therefore also AF ablation in HFREF patients, aiming rather at a rate control strategy. Of course, any conclusion is premature and inappropriate, as lacking of the requisite confirmation by a RCT. On this subject, which is still controversial for many aspects, a well-reasoned and clearly articulated debate could be very useful.

References