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Letter to the Editor J Clin Med Res. 2019;11(4):309

Secondary Prevention of Atrial Fibrillation: Is It Worth Doing?

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To the Editor

Patients coming from pharmacological cardioversion or external transthoracic electrical shock may avoid taking drugs for prevention of atrial fibrillation (AF) recurrences [1]. This concept does not seem suitable for patients in whom retrieval of sinus rhythm has been accomplished with the use of AF ablation (abl) [2, 3]. The latter mode of rhythm control strategy requires that through the entire duration of the blanking period, patients are subjected to anti-arrhythmic drugs to preserve the success of the ablative procedure [3]. Even later, when the period of maximum electrical vulnerability has to be deemed concluded, chronic therapy with anti-arrhythmic drugs at small doses has now become a well-established therapeutic practice, adopted in the vast majority of the dedicated centers [4]. Our thinking in this regard can be summarized as follows: pharmacological or electrical cardioversion should be preferred whenever the pro-arrhythmic burden ensuing from the use of Vaughan Williams 1C drugs and/or sotalol is expected to be elevated to such extent as to result in a detriment to the patient's clinical picture. In these patients, a cautious strategy implying the renunciation to any anti-arrhythmic drug for secondary preventive purposes would be the wisest choice [1]. Vice versa in patients strongly symptomatic for palpitations or dyspnea, with AF refractory to at least one drug unsuccessfully tested, abl can constitute the winning weapon, especially if the patient has been conveniently informed of the high probability of having to undertake a subsequent chronic anti-arrhythmic treatment in order to preserve the best quality of life achieved through the use of abl [5].

In any case, it is necessary to reaffirm the concept clearly expressed by the study AFFIRM [6] according to which management of AF with the rhythm-control strategy offers no survival advantage over the rate-control strategy, and there are potential advantages, such as a lower risk of adverse drug effects, with the rate-control strategy.

Acknowledgments

Not applicable.

Manuscript submitted March 4, 2019, accepted March 12, 2019

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doi: https://doi.org/10.14740/jocmr3810

Funding

None.

Conflict of Interest

None.

Informed Consent

Not applicable.

Author Contributions

Not applicable.

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