AF-SCREEN

www.afscreen.org

AF Screen International Collaboration

ABOUT

Aims of the AF Screen International Collaboration

The aim of this collaborative group is to promote discussion and research about screening for unknown or under-treated atrial fibrillation as a way to reduce stroke and death. We will provide advocacy for implementation of AF screening programs, tailored to the medical systems of individual countries. Our efforts

AF-SCREEN – What's next

- Post-stroke screening white paper – ? Circulation
  - Draft V2 available – feedback from co-authors received
  - Key point work today (not guidelines or consensus)
  - Confront uncertainties and conflicts amongst experts
  - Voting on key points
  - Draft 3 for all members in September

AF-SCREEN – What's next

- Interest groups: Indigenous, Pharmacists,
- Indigenous group – meet this afternoon
  - Australia, New Zealand, USA, Canada, Norway
  - Kylie Gwynne (Au), Katrina Poppe (NZ), Stavros Stavrakis (USA), ? Canada ? Norway
- Pharmacists: screening events to raise AF awareness
  - Not this meeting
  - Paper submitted

AF-SCREEN – What's next

- Large outcomes hard endpoints RCT studies
  - Prospective meta-analysis of those underway and any planned
- Engage with industry to support another large RCT with hard outcomes
  - Seems to be some appetite, esp. after USPSTF
  - May be auspiced by AF-SCREEN

AF-SCREEN – What's next

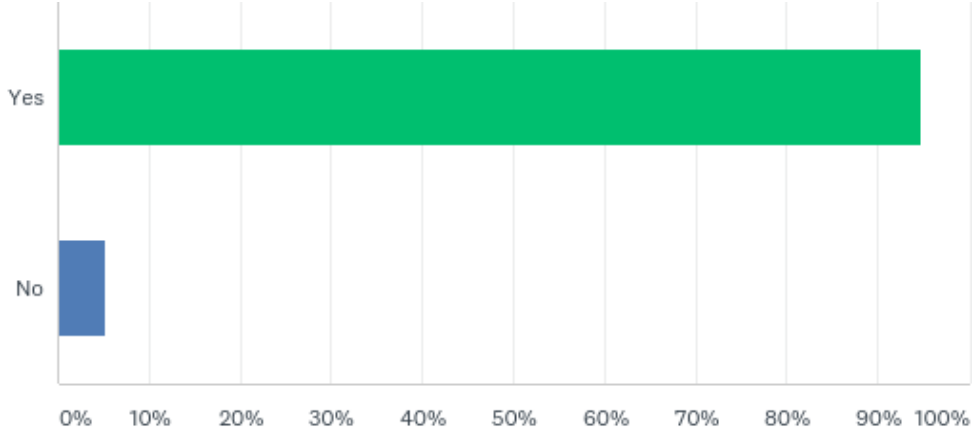
- EU Horizon 2020 large grant 2018-2020
  - Towards risk-based screening strategies in non-communicable diseases
  - Renate Schnabel leading this
- EU COST – European Cooperation in Science and Technology
  - Proposal for a network on AF-SCREENING
  - Led by Claire Buckley, Joe Harbison, Patrick Moran, Breda Smyth, Rónán Collins

AF-SCREEN – What's next

- Survey on management of implanted device-detected AHREs/AF
  - Suggested by Giuseppe Boriani
  - GB, JH, BF
  - Online, anonymous, 57 responses

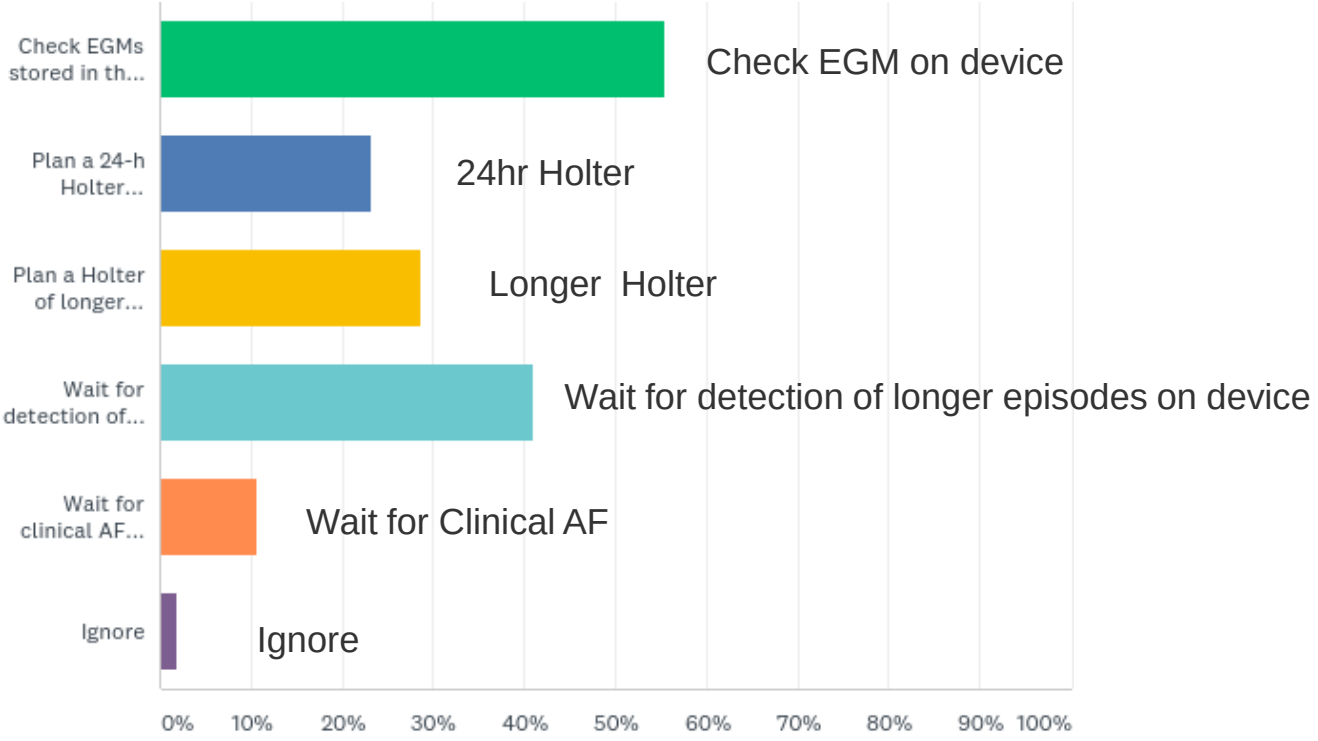
Q1: Do you think that device-detected atrial tachyarrhythmias [subclinical AF/AHRE (Atrial High Rate Episodes)] require medical attention and specific decision-making even if asymptomatic?

Answered: 57 Skipped: 0



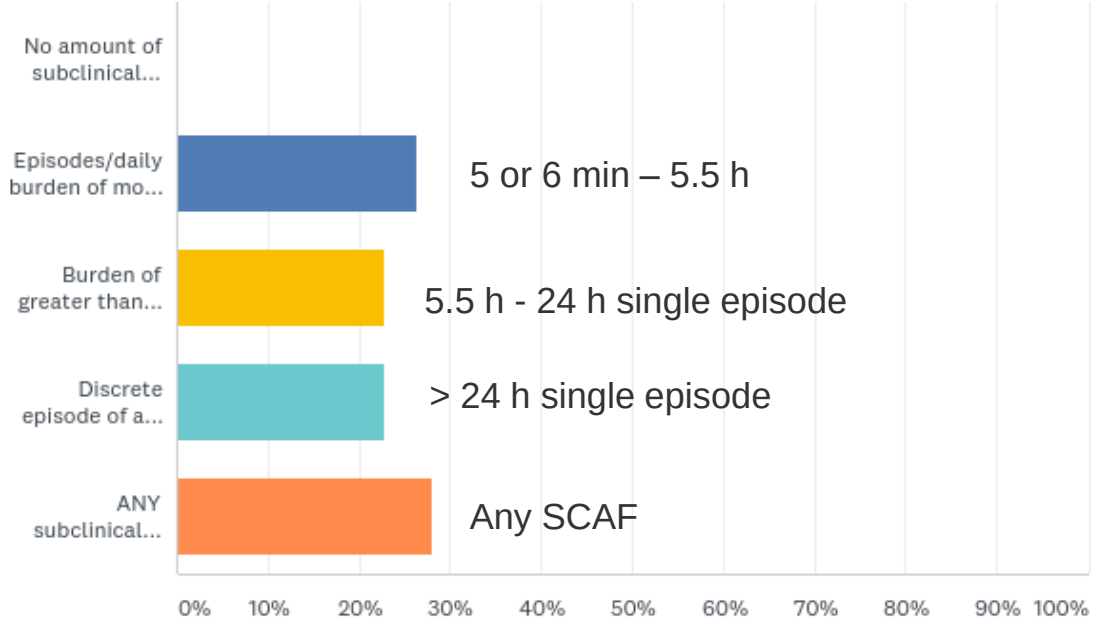
Q2: For subclinical AF/AHRE with a duration between 30 sec and 5 min documented in device logs, what is your approach to arrhythmia confirmation if 12-lead ECG is negative? (Check all that apply)

Answered: 56 Skipped: 1



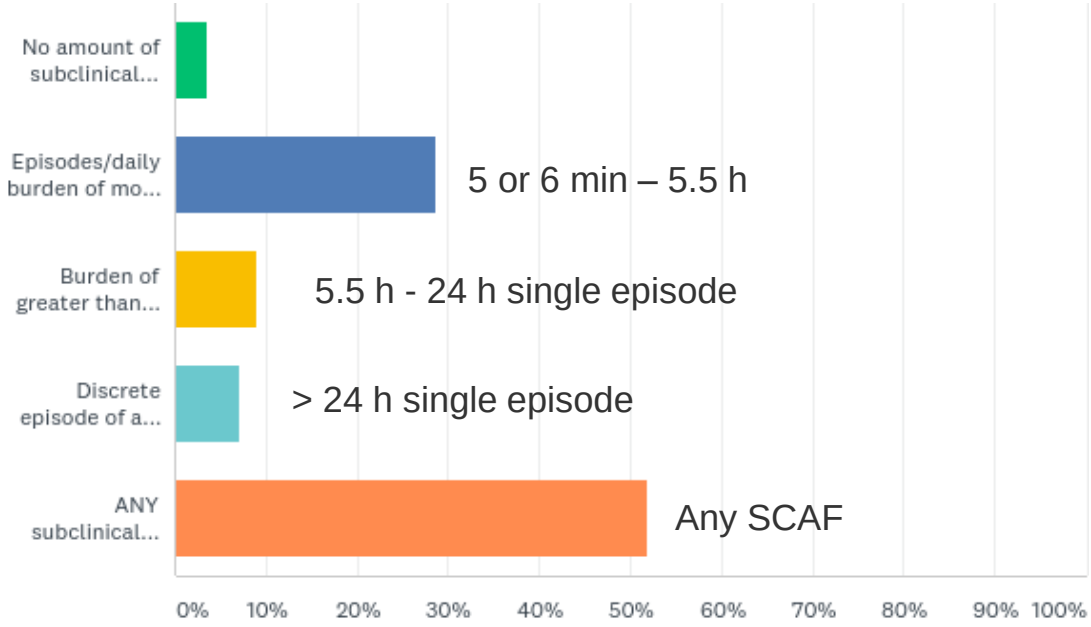
Q5: In the absence of data from a clinical trial, when dealing with a patient with a pacemaker, ICD or ILR who has subclinical AF/AHRE detected, and with a CHA2DS2VASc ≥2 in males or ≥3 in females, what amount of AF would you consider sufficient to recommend the use of chronic oral anticoagulation?

Answered: 57 Skipped: 0



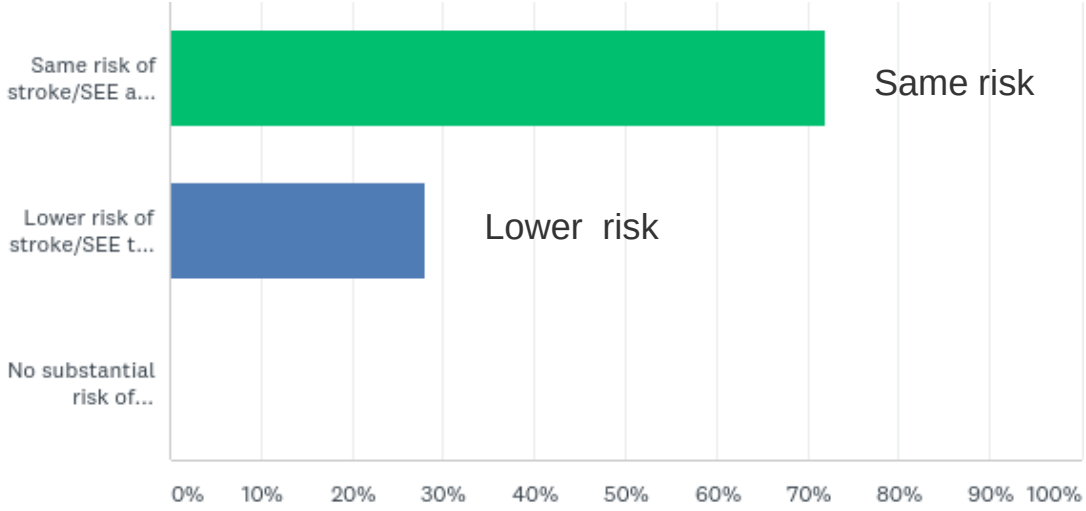
Q6: In the absence of data from a clinical trial, when dealing with a patient with a pacemaker, ICD or ILR who has subclinical AF/AHRE detected, and with a prior STROKE, what amount of AF would you consider sufficient to recommend the use of chronic oral anticoagulation?

Answered: 56 Skipped: 1



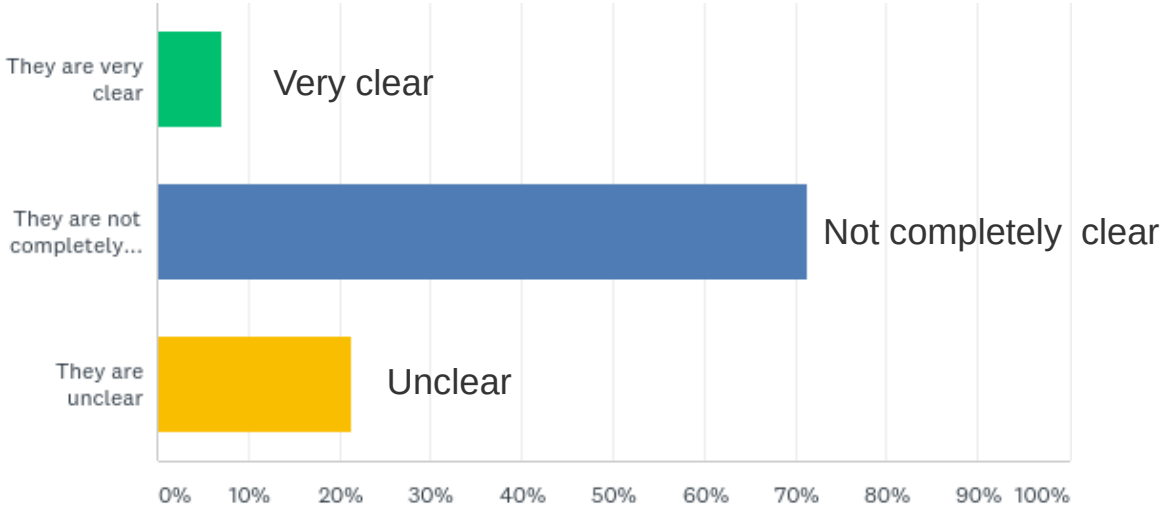
Q8: How do you consider subclinical AF/AHRE with a duration > 24 h in terms of risk of stroke /systemic embolism as compared to the risk associated with clinical AF?

Answered: 57 Skipped: 0



Q9: Do you think that current ESC consensus guidelines on atrial fibrillation are sufficiently clear for helping in decision making on subclinical AF/AHRE?

Answered: 56 Skipped: 1



AF-SCREEN – What's next

- Survey on management of implanted device-detected AHREs/AF
  - Online, anonymous, 57 responses
  - Many of members would not manage device-detected AHREs
  - Wide spectrum of responses. Knowledge gaps indentified
  - ? How to get larger sample ? chain email ? Professional societies

AF-SCREEN – What's next

- ESC 2019 ???
- Your ideas ???

Clinical Review & Education

JAMA | US Preventive Services Task Force | RECOMMENDATION STATEMENT

Screening for Atrial Fibrillation With Electrocardiography

US Preventive Services Task Force

CONCLUSIONS AND RECOMMENDATION The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for atrial fibrillation with ECG. (I statement)

JAMA. 2018;320(5):478-484. doi:10.1001/jama.2018.10321

are first diagnosed with atrial fibrillation at the time of stroke or shortly thereafter.

OBJECTIVE To issue a new US Preventive Services Task Force (USPSTF) recommendation on screening for atrial fibrillation with electrocardiography (ECG).

EVIDENCE REVIEW The USPSTF reviewed the evidence on the benefits and harms of screening for atrial fibrillation with ECG in adults 65 years and older, the effectiveness of screening with ECG for detecting previously undiagnosed atrial fibrillation compared with usual care, and the benefits and harms of anticoagulant or antiplatelet therapy for the treatment of screen-detected atrial fibrillation in older adults.

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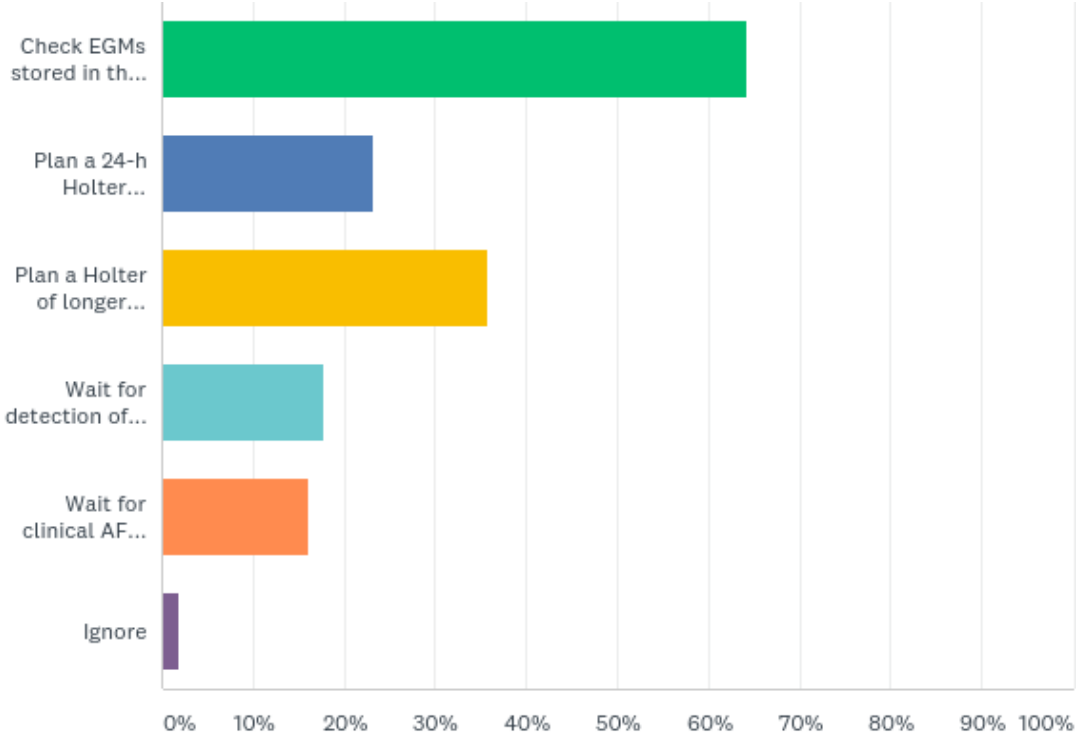
Q2: For subclinical AF/AHRE with a duration between 30 sec and 5 min documented in device logs, what is your approach to arrhythmia confirmation if 12-lead ECG is negative? (Check all that apply)

Answered: 56 Skipped: 1

ANSWER CHOICES	RESPONSES	
Check EGMs stored in the device	55.36%	31
Plan a 24-h Holter recording	23.21%	13
Plan a Holter of longer duration	28.57%	16
Wait for detection of longer episodes by the device	41.07%	23
Wait for clinical AF (detected by ECG or Holter)	10.71%	6
Ignore	1.79%	1
Total Respondents: 56		

Q3: For subclinical AF/AHRE with a duration between 5 min and 24 hours, what is your approach to arrhythmia confirmation if 12-lead ECG is negative? (Check all that apply)

Answered: 56 Skipped: 1



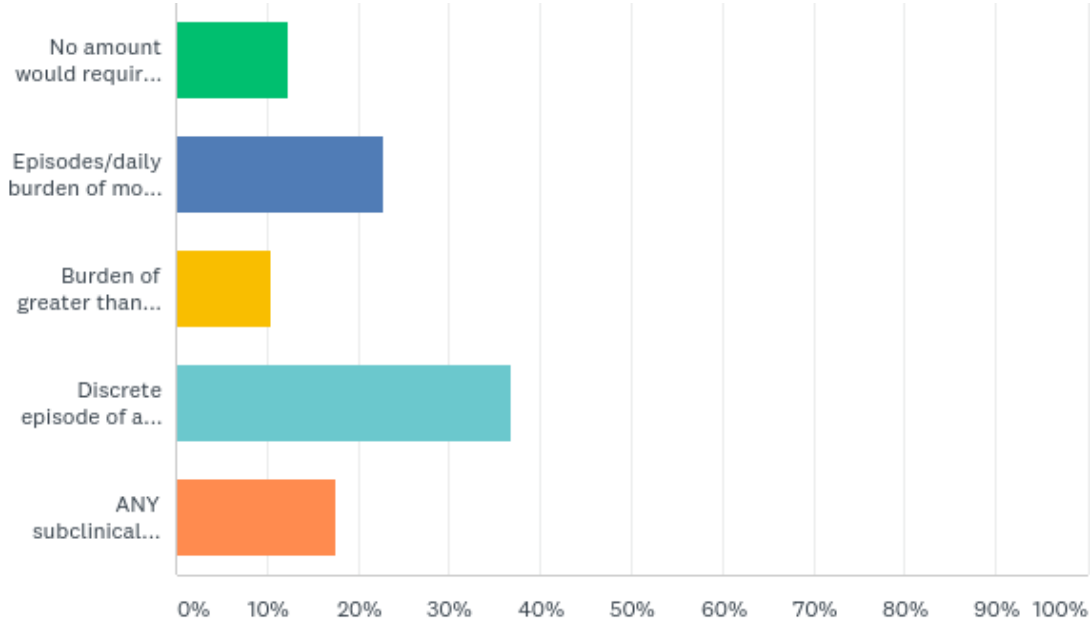
Q4: In the absence of data from a clinical trial, when dealing with a patient with a pacemaker, ICD or ILR who has subclinical AF/AHRE detected, and with a CHA2DS2VASc =1 in males or = 2 in females, what amount of AF would you consider sufficient to recommend the use of chronic oral anticoagulation?

Answered: 57 Skipped: 0

ANSWER CHOICES	RESPONSES	
No amount would require OAC (oral anticoagulation)	12.28%	7
Episodes/daily burden of more than 5-6 minutes	22.81%	13
Burden of greater than 5.5 hours/day	10.53%	6
Discrete episode of at least 24 continuous hours	36.84%	21
ANY subclinical AF/AHRE requires oral anticoagulation	17.54%	10
TOTAL		57

Q4: In the absence of data from a clinical trial, when dealing with a patient with a pacemaker, ICD or ILR who has subclinical AF/AHRE detected, and with a CHA2DS2VASc =1 in males or = 2 in females, what amount of AF would you consider sufficient to recommend the use of chronic oral anticoagulation?

Answered: 57 Skipped: 0



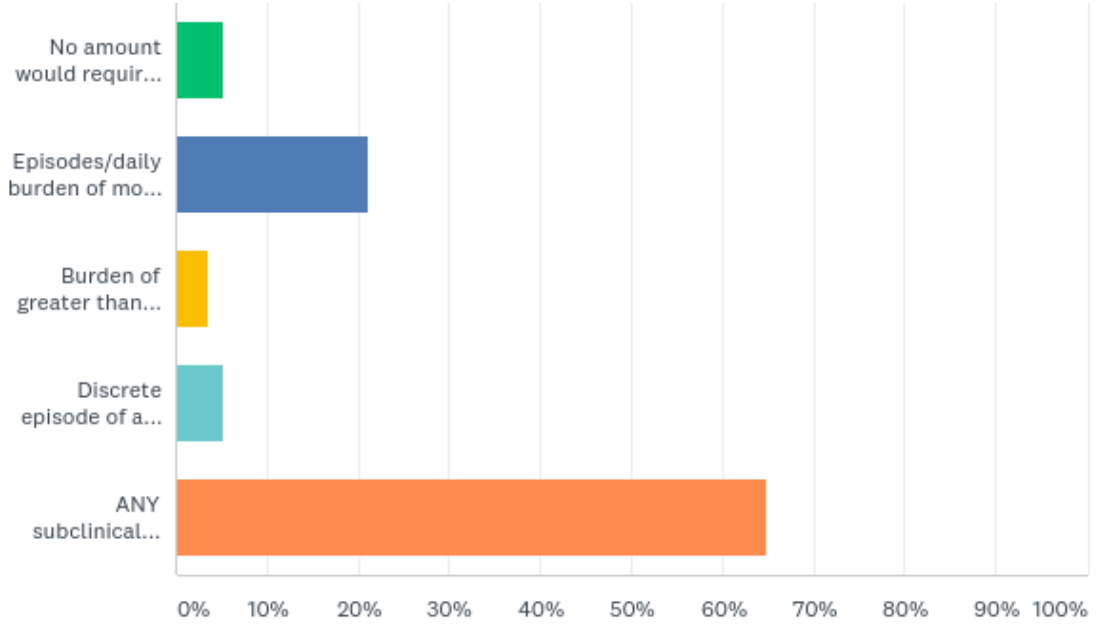
Q6: In the absence of data from a clinical trial, when dealing with a patient with a pacemaker, ICD or ILR who has subclinical AF/AHRE detected, and with a prior STROKE, what amount of AF would you consider sufficient to recommend the use of chronic oral anticoagulation?

Answered: 56 Skipped: 1

ANSWER CHOICES	RESPONSES	
No amount of subclinical AF/AHRE would require OAC (oral anticoagulation)	3.57%	2
Episodes/daily burden of more than 5-6 minutes	28.57%	16
Burden of greater than 5.5 hours/day	8.93%	5
Discrete episode of at least 24 continuous hours	7.14%	4
ANY subclinical AF/AHRE requires oral anticoagulation	51.79%	29
TOTAL		56

Q7: In the absence of data from a clinical trial, when dealing with a patient with a pacemaker, ICD or ILR who has subclinical AF/AHRE detected, and with a prior CARDIOEMBOLIC STROKE, what amount of AF would you consider sufficient to recommend the use of chronic oral anticoagulation?

Answered: 57 Skipped: 0



Q7: In the absence of data from a clinical trial, when dealing with a patient with a pacemaker, ICD or ILR who has subclinical AF/AHRE detected, and with a prior CARDIOEMBOLIC STROKE, what amount of AF would you consider sufficient to recommend the use of chronic oral anticoagulation?

Answered: 57 Skipped: 0

ANSWER CHOICES	RESPONSES	
No amount would require OAC (oral anticoagulation)	5.26%	3
Episodes/daily burden of more than 5-6 minutes	21.05%	12
Burden of greater than 5.5 hours/day	3.51%	2
Discrete episode of at least 24 continuous hours	5.26%	3
ANY subclinical AF/AHRE requires oral anticoagulation	64.91%	37
TOTAL		57

Q8: How do you consider subclinical AF/AHRE with a duration > 24 h in terms of risk of stroke /systemic embolism as compared to the risk associated with clinical AF?

Answered: 57 Skipped: 0

ANSWER CHOICES	RESPONSES	
Same risk of stroke/SEE as clinical AF	71.93%	41
Lower risk of stroke/SEE than clinical AF	28.07%	16
No substantial risk of stroke/SEE associated with subclinical AF/AHRE > 24h	0.00%	0
TOTAL		57

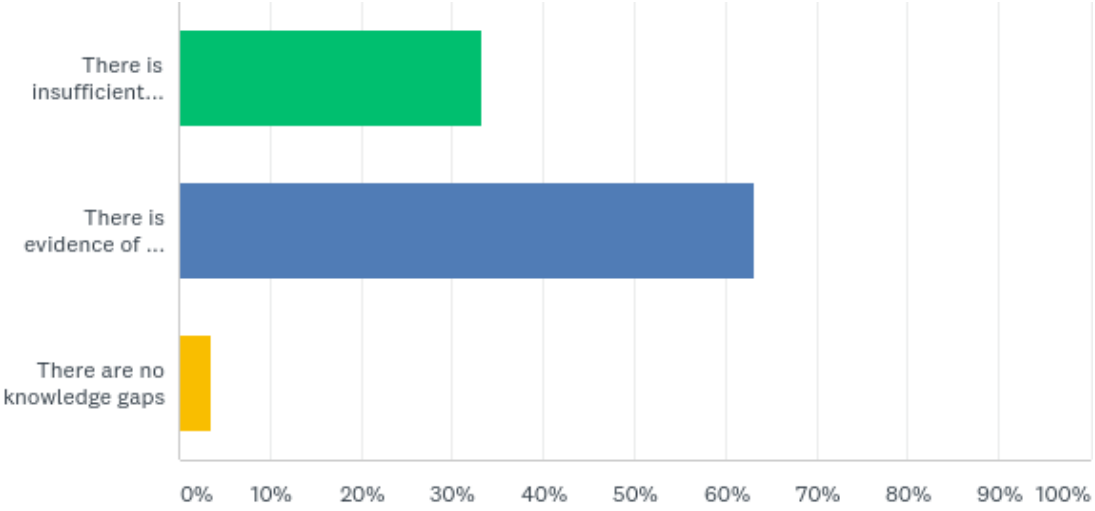
Q9: Do you think that current ESC consensus guidelines on atrial fibrillation are sufficiently clear for helping in decision making on subclinical AF/AHRE?

Answered: 56 Skipped: 1

ANSWER CHOICES	RESPONSES	
They are very clear	7.14%	4
They are not completely clear	71.43%	40
They are unclear	21.43%	12
TOTAL		56

Q10: With regard to decision making for subclinical AF/AHRE, what do you consider as potential knowledge gaps for prescription of oral anticoagulation in patients at risk according to CHA2DS2VaSc score?

Answered: 57 Skipped: 0



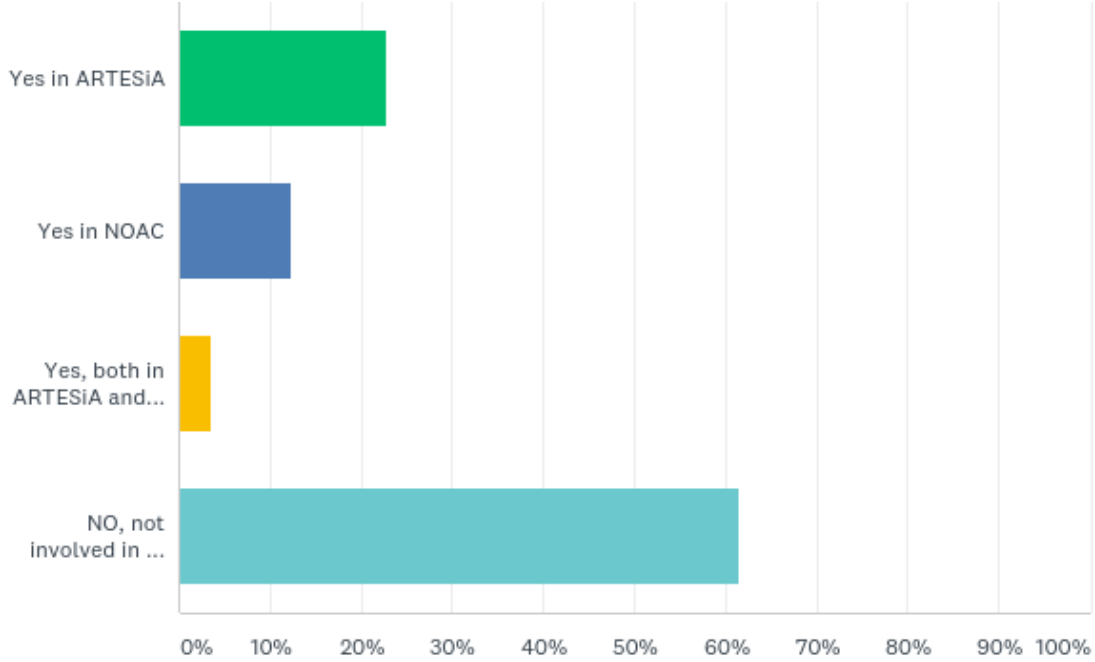
Q10: With regard to decision making for subclinical AF/AHRE, what do you consider as potential knowledge gaps for prescription of oral anticoagulation in patients at risk according to CHA2DS2VaSc score?

Answered: 57 Skipped: 0

ANSWER CHOICES	RESPONSES	
There is insufficient evidence of a substantial risk of stroke /SEE associated with subclinical AF/AHRE	33.33%	19
There is evidence of a substantial risk of stroke /SEE associated with subclinical AF/AHRE but insufficient evidence of a benefit of oral anticoagulant therapy	63.16%	36
There are no knowledge gaps	3.51%	2
TOTAL		57

Q11: Are you or your center involved in one or both the randomized trails evaluating the clinical impact of oral anticoagulation in patients with subclinical AF/AHRE?

Answered: 57 Skipped: 0



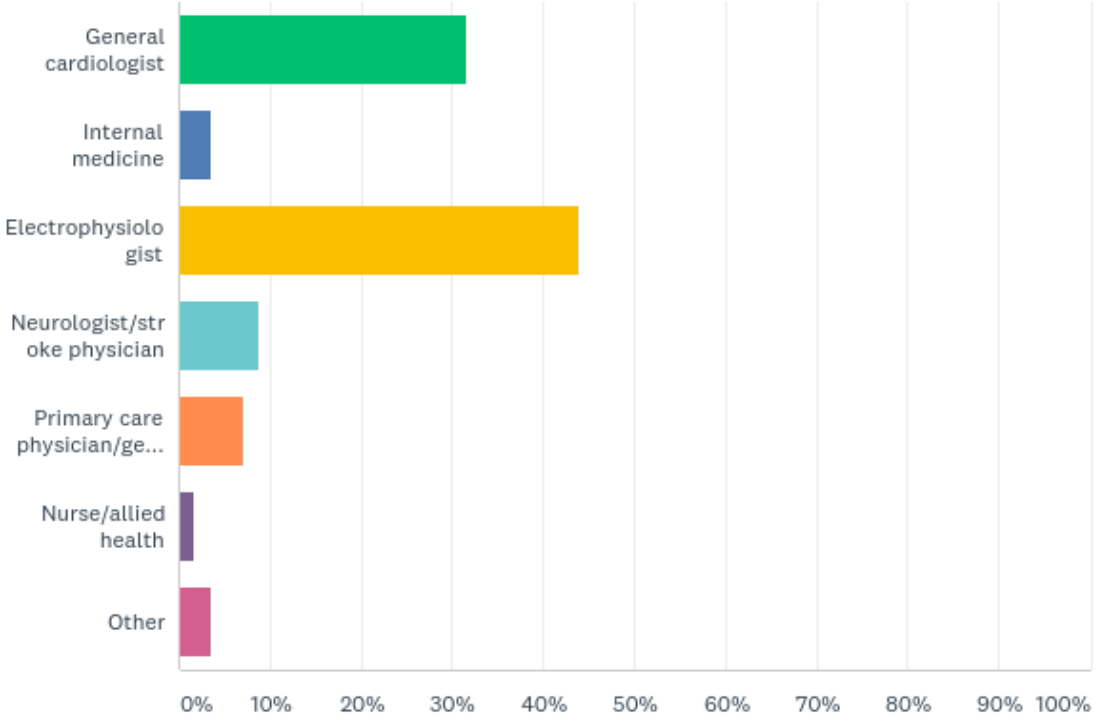
Q11: Are you or your center involved in one or both the randomized trails evaluating the clinical impact of oral anticoagulation in patients with subclinical AF/AHRE?

Answered: 57 Skipped: 0

ANSWER CHOICES	RESPONSES	
Yes in ARTESiA	22.81%	13
Yes in NOAC	12.28%	7
Yes, both in ARTESiA and NOAC	3.51%	2
NO, not involved in any of these trials	61.40%	35
TOTAL		57

Q12: What is your field?

Answered: 57 Skipped: 0



Q12: What is your field?

Answered: 57 Skipped: 0

ANSWER CHOICES	RESPONSES	
General cardiologist	31.58%	18
Internal medicine	3.51%	2
Electrophysiologist	43.86%	25
Neurologist/stroke physician	8.77%	5
Primary care physician/general practitioner	7.02%	4
Nurse/allied health	1.75%	1
Other	3.51%	2
TOTAL		57