Reply to the Editor—From AFFIRM to EAST—Better rhythm control and general AF management explain differences in outcomes

The EAST-AFNET 4 trial showed clinical benefit of systematic, early initiation of rhythm control therapy in patients with AF, with 21% fewer cardiovascular events compared to rhythm control given only to symptomatic patients.1 Patients with recently diagnosed AF randomized to rhythm control in the AFFIRM trial did not experience such benefits.2

Improvements in the management of patients with AF can explain this difference. (1) Anticoagulation was routinely withheld after “successful” rhythm restoration in the days of AFFIRM, whereas >90% of the patients randomized in EAST-AFNET 4 were receiving continued anticoagulation, without intergroup differences. (2) We have developed methods to safely use antiarrhythmic drugs in patients with AF.3 This results in low adverse event rates, as seen in the Catheter Ablation Versus Anti-arrhythmic Drug Therapy for Atrial Fibrillation (CABANA)4 and EAST-AFNET 41 safety outcomes. This knowledge was not available at the time of AFFIRM.5 (3) Catheter ablation is now routinely available and used, especially in patients with recurrent AF on rhythm control. These improvements probably explain the clinical benefit of systematic, early rhythm control in patients in EAST-AFNET 41 in contrast to the early AF patients in AFFIRM.2

In his letter, Dr Wang also calls for subanalyses of the EAST-AFNET 4 trial. These are ongoing, and we hope to report the first results later this year. Finally, all patients enrolled in EAST-AFNET 4 had AF documented by ECG. The option of screening for AF was not often used.

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References

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ERRATUM

In the article “2017 HRS expert consensus statement on cardiovascular implantable electronic device lead management and extraction,” by Fred M. Kusumoto, Mark H. Schoenfeld, and Bruce L. Wilkoff, et al., published in the December 2017 issue of Heart Rhythm (Volume 14, Issue 12, ppE503-E551, doi: https://doi.org/10.1016/j.hrthm.2017.09.001), in Table 4, there is an incorrect reference cited in row 13 regarding the “Presence of dual-coil ICD.” The reference cited for associated risk “2.7-fold ↑ risk of 30-day mortality” should be 102, not 62. The error is regretted.