Fibrillazione atriale ed EP

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Fibrillazione atriale 2024
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SGLT2i se FA+scompenso anche a FE normale (e aggiungo: scompenso transitorio)
Sodium-glucose cotransporter-2 inhibitors are recommended for patients with HF and AF regardless of left ventricular ejection fraction to reduce the risk of HF hospitalization and cardiovascular death. **I**

Anticoagulanti anche con CHA2DS2-VA = 0 se cardiomiopatia ipertrofica o amiloidosi cardiaca
Oral anticoagulation is recommended in all patients with AF and hypertrophic cardiomyopathy or cardiac amyloidosis, regardless of CHA2DS2-VA score, to prevent ischaemic stroke and thromboembolism. **I**

Solo classe IIb scoagulare se asintomatico per FA scoperta tramite PMK o altri device. Non è chiaro se ci sia una durata oltre la quale può essere indicato
Direct oral anticoagulant therapy may be considered in patients with asymptomatic device-detected subclinical AF and elevated thromboembolic risk to prevent ischaemic stroke and thromboembolism, excluding patients at high risk of bleeding. **IIb**
The duration and burden of subclinical AF that could indicate potential benefit from OAC remains uncertain.

Proibito dare dosi ridotte di DOAC off label
A reduced dose of DOAC therapy is not recommended, unless patients meet DOAC-specific criteria, to prevent underdosing and avoidable thromboembolic events. **III**

Sotto i 75 anni, sostituire a tutti VKA con DOAC
Maintaining VKA treatment rather than switching to a DOAC may be considered in patients aged ≥ 75 years on clinically stable therapeutic VKA with polypharmacy to prevent excess bleeding risk. **IIb**

Proibito "potenziare" off label con antipiastrinici (neppure in caso di recidiva di ictus). Inutile inoltre cambiare anticoagulante in caso di recidiva.
Adding antiplatelet treatment to oral anticoagulation is not recommended in AF patients for the goal of preventing ischaemic stroke or thromboembolism.**III**
Adding antiplatelet treatment to anticoagulation is not recommended in patients with AF to prevent recurrent embolic stroke **III**
Switching from one DOAC to another, or from a DOAC to a VKA, without a clear indication is not recommended in patients with AF to prevent recurrent embolic stroke. **III**

La chiusura dell'auricola per via percutanea può essere indicata se controindicati anticoagulanti
Percutaneous LAA occlusion may be considered in patients with AF and contraindications for long-term anticoagulant treatment to prevent ischaemic stroke and thromboembolism. **IIb**

A chi ha FA e subisce intervento cardiochirurgico è bene (classe I e non più IIb) chiudere l'auricola
Surgical closure of the left atrial appendage is recommended as an adjunct to oral anticoagulation in patients with AF undergoing cardiac surgery to prevent ischaemic stroke and thromboembolism. **I**

La chiusura dell'auricola chirurgica è più indicata se già si interviene chirurgicamente per eseguire ablazione (giusto!), meno se la si esegue apposta in chi non può essere anticoagulato (strano! Forse perché si potrebbe provvedere in modo non chirurgico)
Surgical closure of the left atrial appendage should be considered as an adjunct to oral anticoagulation in patients with AF undergoing endoscopic or hybrid AF ablation to prevent ischaemic stroke and thromboembolism **IIa**
Stand-alone endoscopic surgical closure of the left atrial appendage may be considered in patients with AF and contraindications for long-term anticoagulant treatment to prevent ischaemic stroke and thromboembolism **IIb**

Per cardiovertire, scoagulare entro 24 ore (non 48!) o eseguire TEE
Early cardioversion is not recommended without appropriate anticoagulation or transoesophageal echocardiography if AF duration is longer than 24 h, or there is scope to wait for spontaneous cardioversion. **III**

La pausa alla fine della FA spinge all'ablazione, non necessariamente al PMK
Atrial fibrillation catheter ablation should be considered in patients with AF-related bradycardia or sinus pauses on AF termination to improve symptoms and avoid pacemaker implantation. **IIa**

Non si può interrompere la scoagulazione prima dell'ablazione (classe I) e deve continuare per

almeno 2 mesi dopo
Uninterrupted oral anticoagulation is recommended in patients undergoing AF catheter ablation to prevent peri-procedural ischaemic stroke and thromboembolism. **I**
Continuation of oral anticoagulation is recommended for at least 2 months after AF ablation in all patients, irrespective of rhythm outcome or CHA2DS2-VA score, to reduce the risk of peri-procedural ischaemic stroke and thromboembolism. **I**

Ablazione percutanea in FA parossistica passa da classe IIa a I
Catheter ablation is recommended as a first-line option within a shared decision-making rhythm control strategy in patients with paroxysmal AF, to reduce symptoms, recurrence, and progression of AF. **I**

Ablazione percutanea in FA resistente ai farmaci è in classe I anche se è persistente; è invece in classe IIb se non si vuole neanche provare a usarli (insomma: se è parossistica si può decidere di ablare subito, se è persistente è meglio provare prima con i farmaci)
Catheter ablation is recommended in patients with paroxysmal or persistent AF resistant or intolerant to antiarrhythmic drug therapy to reduce symptoms, recurrence, and progression of AF. **I**
Catheter ablation may be considered as a first-line option within a shared decision-making rhythm control strategy in selected patients with persistent AF to reduce symptoms, recurrence, and progression of AF. **IIb**

Questo che segue è un po' oscuro per me
In caso di FA persistente e sintomatica non rispondente ai farmaci si dovrebbe (IIa) pensare all'ablazione endoscopica (cioè epicardica) o ibrida (transcatetere + epicardica). Meno utile (IIb) (non so perché) in caso di parossistica sintomatica non rispondente ai farmaci e non risolta con l'ablazione percutanea.
Endoscopic and hybrid ablation procedures should be considered in patients with symptomatic persistent AF refractory to AAD therapy to prevent symptoms, recurrence, and progression of AF, within a shared decision-making rhythm control team of electrophysiologists and surgeons. **IIa**
Endoscopic and hybrid ablation procedures may be considered in patients with symptomatic paroxysmal AF refractory to AAD therapy and failed percutaneous catheter ablation strategy to prevent symptoms, recurrence, and progression of AF, within a shared decision-making rhythm control team of electrophysiologists and surgeons. **IIb**

Il chirurgo che opera la mitrale in FA deve eseguire anche l'ablazione. Dovrebbe (IIa) anche se opera su altra parte del cuore
Concomitant surgical ablation is recommended in patients undergoing mitral valve surgery and AF suitable for a rhythm control strategy to prevent symptoms and recurrence of AF, with shared decision-making supported by an experienced team of electrophysiologists and arrhythmia surgeons. **I**
Concomitant surgical ablation should be considered in patients undergoing non-mitral valve cardiac surgery and AF suitable for a rhythm control strategy to prevent symptoms and recurrence of AF, with shared decision-making supported by an experienced team of electrophysiologists and arrhythmia surgeons. **IIa**

Andrebbero scoagulati (IIa) anche i post-chirurgici e le FA da causa esterna (per me è strano)
Long-term oral anticoagulation should be considered in patients with post-operative AF after cardiac and non-cardiac surgery at elevated thromboembolic risk, to prevent ischaemic stroke and thromboembolism. **IIa**
Long-term oral anticoagulation should be considered in suitable patients with trigger-induced AF at elevated thromboembolic risk to prevent ischaemic stroke and systemic thromboembolism. **IIa**

FA clinica: almeno 30 secondi di ECG
The minimum duration to establish the diagnosis of clinical AF for ambulatory ECG is not clear and depends on the clinical context. Periods of 30 s or more may indicate clinical concern, and trigger further monitoring or risk stratification for thromboembolism.

Controllo frequenza: <110 (minore se persistono sintomi
Rate control target = resting heart rate <110 b.p.m. (lenient control), with stricter control with continuing symptoms. **IIa**

L'ablazione in FA persistente l'ablazione con catetere è solo IIb, a meno di tachicadiomiopatia (classe I) e in pazienti selezionati per migliorare la prognosi (IIa)
In patients with HFrEF: Class I if high probability of tachycardia-induced cardiomyopathy; and Class IIa in selected patients to improve prognosis

Score: ora non si usa più il sesso ma CHA2DS2-VA, ed è ad alto rischio se > 1.
CHA2DS2-VASc: Congestive heart failure**, H**ypertension**, A**ge ≥75 years (doubled)**, D**iabetes mellitus, prior **S**troke or TIA or thromboembolism (doubled)**, V**ascular disease, **A**ge 65 to 74 years**, S**ex **c**ategory (ora è stata abolita Sc, cioè sex category)

Anche con CHA2DS2-VA score 1 si dovrebbe scoagulare (IIa)
A CHA2DS2-VA score of 1 should be considered an indicator of elevated thromboembolic risk for decisions on initiating oral anticoagulation. **IIa**

Tabella riduzione dosaggio DOAC

DOAC	Standard full dose	Criteria for dose reduction	Reduced dose only if criteria met
Apixaban	5 mg twice daily	Two out of three needed for dose reduction: (i) age ≥80 years (ii) body weight ≤60 kg (iii) serum creatinine ≥133 mmol/L.	2.5 mg twice daily
Dabigatran	150 mg twice daily	Dose reduction recommended if any apply: (i) age ≥80 years (ii) receiving concomitant verapamil. Dose reduction considered on an individual basis if any apply: (i) age 75–80 (ii) moderate renal impairment (creatinine clearance 30–50 mL/min) (iii) patients with gastritis, oesophagitis, or gastro-oesophageal reflux (iv) others at increased risk of bleeding.	110 mg twice daily
Edoxaban	60 mg once daily	Dose reduction if any apply: (i) moderate or severe renal impairment (creatinine clearance 15–50 mL/min) (ii) body weight ≤60 kg (iii) concomitant use of ciclosporin, dronedarone, erythromycin, or ketoconazole.	30 mg once daily
Rivaroxaban	20 mg once daily	Creatinine clearance 15–49 mL/min.	15 mg once daily

In caso di scompenso, non basta "pace and ablate", ma anche RCT
Atrioventricular node ablation combined with cardiac resynchronization therapy should be considered in severely symptomatic patients with permanent AF and at least one hospitalization for HF to reduce symptoms, physical limitations, recurrent HF hospitalization, and mortality. **IIa**

Cordarone ammissibile (IIb) per ridurre la frequenza in caso di compromissione emodinamica
Intravenous amiodarone, digoxin, esmolol, or landiolol may be considered in patients with AF who have haemodynamic instability or severely depressed LVEF to achieve acute control of heart rate

Dosaggi massimi per controllo frequenza
Metoprolol tartrate 100 mg twice daily
Bisoprolol 20 mg once daily
Atenolol 100 mg once daily
Esmolol 500 µg/kg i.v. bolus over 1 min; followed by 50–300 µg/kg/min
Landiolol 100 µg/kg i.v. bolus over 1 min; followed by 10–40 µg/kg/min
Nebivolol 10 mg once daily
Carvedilol 50 mg twice daily

Scoagulazione dopo cardioversione: 4 settimane a tutti anche con CHA2DS2VA 0, eccetto se meno di 24 ore
Short-term OAC after cardioversion (4 weeks) for all patients, even if CHA2DS2-VA = 0 (optional if AF onset definitely <24 h and low thromboembolic risk) Long-term OAC for all patients according to thromboembolic risk assessment

Si potrebbe evitare il TEE dopo 3 settimane di scoagulazione
Transoesophageal echocardiography is recommended if 3 weeks of therapeutic oral anticoagulation has not been provided, for exclusion of cardiac thrombus to enable early cardioversion. **I**

I farmaci 1C non sono proibiti in caso di ipertrofia non grave
Intravenous flecainide or propafenone is recommended when pharmacological cardioversion of recent-onset AF is desired, excluding patients with severe left ventricular hypertrophy, HFrEF, or coronary artery disease. **I**

Non cardiovertire farmacologicamente con QT lungo
Pharmacological cardioversion is not recommended for patients with sinus node dysfunction, atrioventricular conduction disturbances, or prolonged QTc (>500 ms), unless risks for proarrhythmia and bradycardia have been considered. **III**

Dosi d'attacco classe IC. Associare farmaci per prevenire l'insorgenza di flutter
Flecainide Oral 200–300 mg Intravenous 1–2 mg/kg over 10 min
Propafenone Oral 450–600 mg Intravenous 1.5–2 mg/kg over 10 min

Concomitant use of a beta-blocker, diltiazem, or verapamil should be considered in AF patients treated with flecainide or propafenone, to prevent 1:1 conduction if their rhythm is transformed to atrial flutter. **IIa**

Sotalolo in classe IIb
Sotalol may be considered in patients with AF requiring long-term rhythm control with normal LVEF or coronary artery disease to prevent recurrence and progression of AF, but requires close monitoring of QT interval, serum potassium levels, renal function, and other proarrhythmia risk factors. **IIb**

Nell'alto rischio emorragico, andrebbe considerata la riduzione del Rivaroxaban, del Dabigatran o del VKA se somministrato con antiaggreganti
Rivaroxaban 15 mg once daily should be considered in preference to rivaroxaban 20 mg once daily when combined with antiplatelet therapy in patients where concerns about bleeding risk prevail over concerns about stent thrombosis or ischaemic stroke. **IIa**
Dabigatran 110 mg twice daily should be considered in preference to dabigatran 150 mg twice daily when combined with antiplatelet therapy in patients where concerns about bleeding risk prevail over concerns about stent thrombosis or ischaemic stroke. **IIa**
Carefully regulated VKA dosing with a target INR of 2.0–2.5 and TTR >70% should be considered when combined with antiplatelet therapy in AF patients to mitigate bleeding risk. **IIa**

Triplice (meglio con Clopidogrel) nelle sindromi coronariche solo 1 settimana (classe I) e massimo 1 mese (classe IIa). Idem nelle angioplastiche al di fuori della SCA (durata duplice 6 mesi invece di 1 anno)
Early cessation (≤1 week) of aspirin and continuation of an oral anticoagulant (preferably DOAC) with a P2Y12 inhibitor (preferably clopidogrel) for up to 12 months is recommended in AF patients with ACS undergoing an uncomplicated PCI to avoid major bleeding, if the risk of thrombosis is low or bleeding risk is high. **I**
Triple therapy with aspirin, clopidogrel, and oral anticoagulation for longer than 1 week after an ACS should be considered in patients with AF when ischaemic risk outweighs the bleeding risk, with the total duration (≤1 month) decided according to assessment of these risks and clear documentation of the discharge treatment plan. **IIa**
After uncomplicated PCI, early cessation (≤1 week) of aspirin and continuation of an oral anticoagulant and a P2Y12 inhibitor (preferably clopidogrel) for up to 6 months is recommended to avoid major bleeding, if ischaemic risk is low. **I**
Triple therapy with aspirin, clopidogrel, and an oral anticoagulant for longer than 1 week should be considered after PCI when the risk of stent thrombosis outweighs the bleeding risk, with the total duration (≤1 month) decided according to assessment of these risks and clear documentation. **IIa**
Antiplatelet therapy beyond 12 months is not recommended in stable patients with chronic coronary or vascular disease treated with oral anticoagulation, due to lack of efficacy and to avoid major bleeding. **III**

Stroke di incerta origine: indagare ma non scoagulare
Prolonged monitoring for AF is recommended in patients with embolic stroke of unknown source to inform on AF treatment decisions. **I**
Initiation of oral anticoagulation in embolic stroke of unknown source patients without documented AF is not recommended due to lack of efficacy in preventing ischaemic stroke and thromboembolism. **III**

Durante gravidanza: cardioversione se instabile, scoagulazione con LWMH, beta-bloccanti 1 selettivi e in seconda battuta digossina per la frequenza, cardioversione in caso di cardiomiopatia ipertrofica, solo IIb classe I c
Vedi pagina 56 linee guida

A una certa età l'holter sarebbe indicato di routine
Population-based screening for AF using a prolonged non-invasive ECG-based approach should be considered in individuals aged ≥75 years, or ≥65 years with additional CHA2DS2-VA risk factors to ensure earlier detection of AF. **IIa.**

Tra i punti oscuri, quelli che più mi hanno colpito sono:
- The selection of which patients with asymptomatic device-detected subclinical AF benefit from OAC therapy needs to be defined
- There is a lack of evidence whether and when to (re)start anticoagulation after intracranial haemorrhage
- There is lack of evidence about optimal anticoagulation in patients with ischaemic stroke or left atrial thrombus while being treated with OAC
- Uncertainty exists on the time of duration of AF and risk of stroke when performing a cardioversion.

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PRECEDENTI

N.B. questo appunto è fuori dalle linee guida: https://www.jwatch.org/na50217/2019/10/30/are-patients-with-short-duration-atrial-fibrillation-risk
A seconda del CHADSVASC è significativa o meno la durata rilevata all'Holter per decidere se scoagulare

Embolia polmonare
Apixaban 10x2 per 7 giorni (poi ridotto a 5x2, senza ulteriori riduzioni, nonostante peso eccetera)
Dabigatran 150x2 fisso
Edoxaban: 60 mg fisso (se non ridotto per stessi motivi di FA)
Rivaroxaban: 15x2 per 3 settimane, poi 20 mg senza ulteriori riduzioni

Prevenzione embolia a lungo termine
Apixaban 2,5x2
Dabigatran 150x2
Edoxaban: 60 mg
Rivaroxaban: 10 mg (20 se ad alto rischio)

Dose saltata
Si può prendere fino a metà intervallo

Doppia dose
Se regime 2 volte al giorno, saltare una dose
Se regime 1 volta al giorno, continuare

Funzione renale
Usare la formula di Cockcroft–Gault e non MDRD
Iniezione intramuscolare per vaccino
Saltare la dose se BID, tardare la dose se QD

Switch

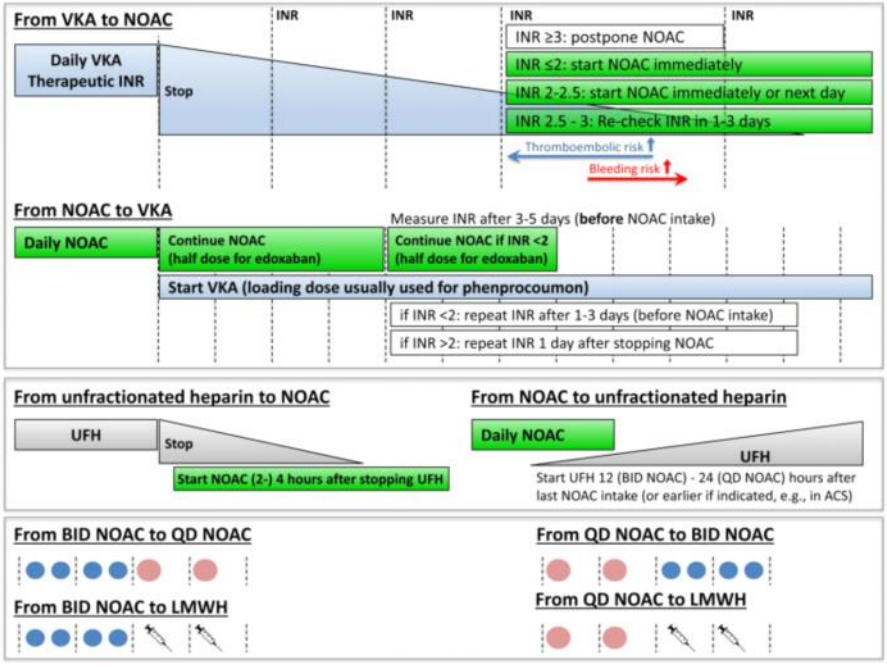

Figure 4 Switching between NOACs and other anticoagulants. ACS, acute coronary syndrome; BID, twice daily; INR, international normalized ratio; LMWH, low molecular weight heparin; NOAC, non-vitamin K antagonist oral anticoagulant; QD, once daily; UFH, unfractionated heparin; VKA, vitamin K antagonist.

Somministrazione
Rivaroxaban con il cibo
Dabigatran non frantumato nel sondino n.g.

Insufficienza renale

Given the lack of strong evidence the decision to anticoagulate and (if so) whether to use a NOAC or VKA in patients with end-stage renal failure or on dialysis requires a high degree of individualization.

Sospensione anticoagulanti pre-chirurgia

Table 12 Classification of elective surgical interventions according to bleeding risk

Minor risk interventions (i.e. infrequent bleeding and with low clinical impact)
Dental extractions (1–3 teeth), paradontal surgery, implant positioning, subgingival scalling/cleaning
Cataract or glaucoma intervention
Endoscopy without biopsy or resection
Superficial surgery (e.g. abscess incision; small dermatologic excisions, skin biopsy)
Pacemaker or ICD implantation (except complex procedures)
Electrophysiological study or catheter ablation (except complex procedures)
Routine elective coronary/peripheral artery intervention (except complex procedures)
Intramuscular injection (e.g. vaccination)
Low-risk interventions (i.e. infrequent bleeding or with non-severe clinical impact)
Complex dental procedures
Endoscopy with simple biopsy
Small orthopaedic surgery (foot, hand, arthroscopy, . . .)
High-risk interventions (i.e. frequent bleeding and/or with important clinical impact)
Cardiac surgery
Peripheral arterial revascularization surgery (e.g. aortic aneurysm repair, vascular bypass)
Complex invasive cardiological interventions, including lead extraction, (epicardial) VT ablation, chronic total occlusion PCI etc.
Neurosurgery
Spinal or epidural anaesthesia; lumbar diagnostic puncture
Complex endoscopy (e.g. multiple/large polypectomy, ERCP with sphincterotomy etc.)
Abdominal surgery (incl. liver biopsy)
Thoracic surgery
Major urologic surgery/biopsy (incl. kidney)
Extracorporeal shockwave lithotripsy
Major orthopaedic surgery

For each patient, individual factors relating to bleeding and thromboembolic risk need to be taken into account and be discussed with the operating physician and the patient (see *Figure 13*).

	Dabigatran		Apixaban - Edoxaban - Rivaroxaban	
No perioperative bridging with LMWH / UFH				
Minor risk procedures: - Perform procedure at NOAC trough level (i.e., 12 h / 24 h after last intake). - Resume same day or latest next day.				
	Low risk	**High risk**	**Low risk**	**High risk**
CrCl ≥80 ml/min	≥ 24 h	≥ 48 h	≥ 24 h	≥ 48 h
CrCl 50-79 ml/min	**≥ 36 h**	**≥ 72 h**		
CrCl 30-49 ml/min	**≥ 48 h**	**≥ 96 h**		
CrCl 15-29 ml/min	Not indicated	Not indicated	**≥ 36 h**	
CrCl <15 ml/min	No official indication for use			

Important:

- Timing of interruption may require adaptation based on individual patient characteristics (Fig. 13)
- In patients / situations with risk of NOAC accumulation (renal insufficiency, older age, concomitant medication, see Fig. 6) pausing the NOAC 12-24 hours earlier may be considered.[207,208]
- Resume full dose of NOAC 24h after low-risk- and 48 (-72) h after high-risk interventions

Cardiopatia ischemica

Triplice (con Clopidogrel) per una settimana (un mese se angioplastica complessa o trombosi di stent), duplice da subito se non angioplastica. Dopo un anno solo NAO. Se angioplastica in elezione già dopo 6 mesi solo NAO.

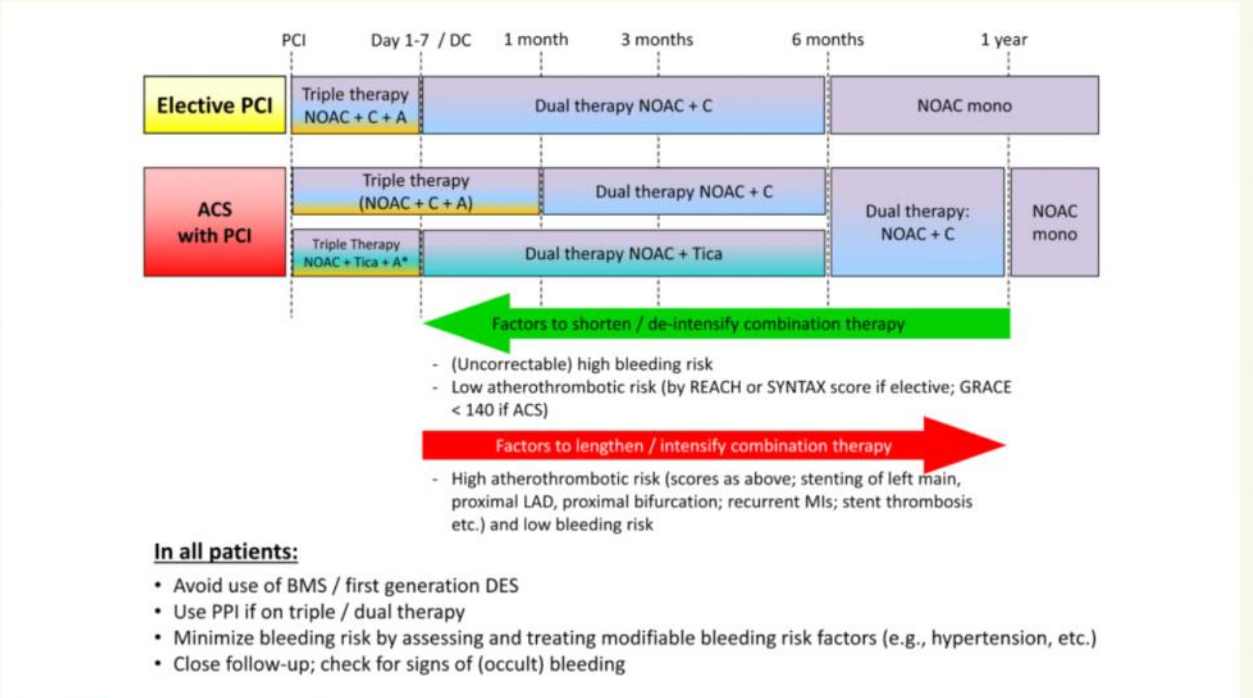

Figure 17 Anticoagulation therapy after elective PCI or ACS in patients with AF. 'Shorten/de-intensify': e.g. discontinuing Aspirin or P_2Y_{12} inhibitor at an earlier stage. 'Lengthen/intensify': e.g. continuing triple combinations longer, or continuing P_2Y_{12} inhibitor longer. A: aspirin 75–100 mg QD; C: clopidogrel 75 mg QD; Tica: Ticagrelor 90 mg BID. *If triple therapy needs to be continued after discharge clopidogrel is preferred over ticagrelor (due to lack of data). ACS, acute coronary syndrome; AF, atrial fibrillation; BID, twice daily; BMS, bare metal stent; DES, drug-eluting stent; LAD, left anterior descending artery; MI, myocardial infarction; NOAC, non-vitamin K antagonist oral anticoagulant; PCI, percutaneous coronary intervention; PPI, proton pump inhibitor; QD, once daily.

Dopo cardioversione, continuare l'anticoagulazione anche in caso di chiaro stimolo (embolia polmonare, ecc) perché comunque denota una tendenza. Per Chadsvasc 0 solo 1 mese, o addirittura

forse nulla se durata meno di 24 ore.
Trombo persistente: cambiare NAO o passare a VKA.

In caso di ictus, durante l'attesa prima dei NAO considerare ASA, sia se di origine ischemica sia se in trasformazione emorragica.

In caso di emorragia cerebrale senza causa (come ipertensione non controllata, malformazione vascolare, triplice) non si può dare anticoagulante.

Antiplatelet therapy alone (monotherapy or aspirin in combination with clopidogrel) is not recommended for stroke prevention in AF.
Estimated bleeding risk, in the absence of absolute contraindications to OAC, should not in itself guide treatment decisions to use OAC for stroke prevention.
Clinical pattern of AF (i.e. first detected, paroxysmal, persistent, long-standing persistent, permanent) should not condition the indication to thromboprophylaxis

Varie
Clinical pattern of AF (i.e. first detected, paroxysmal, persistent, long-standing persistent, permanent) should not condition the indication to thromboprophylaxis (quindi, qui dice, va scoagulato anche se primo episodio regredito da solo).
Pharmacological cardioversion of AF is indicated only in a haemodynamically stable patient, after consideration of the thrombo-embolic
risk. (questo è ovvio: se è instabile va fatta cardioversione elettrica)
For patients with sick-sinus syndrome, atrioventricular conduction disturbances or prolonged QTc (>500 ms), pharmacological cardioversion should not be attempted unless risks for proarrhythmia and bradycardia have been considered.

Cardioversione
In patients with a definite duration of AF <_24 h and a very low stroke risk (CHA2DS2-VASc of 0 in men or 1 in women) post-cardioversion
anticoagulation for 4 weeks may be omitted. IIb (IIb non mi convince molto, ne deduco: va bene scoagulare anche per classe 0!)
Preferably, therapeutic OAC for at least 3 weeks before ablation (class I), or Alternatively, the use of TOE to exclude LA thrombus before ablation (class IIa) . (anche se noi non lo facciamo, si potrebbe cardiovertire senza TEE dopo 3 settimane)

Ablazione
performance of the ablation procedure without OAC interruption is recommended. (Da noi credo la interrompono)

Scoagulazione
Long-term OAC therapy to prevent thrombo-embolic events may be considered in patients at risk for stroke with postoperative AF after cardiac surgery, considering the anticipated net clinical benefit of OAC therapy and informed patient preferences. 2b (mi fa piacere che sia IIb, perché dopo intervento non mi sembra una buona idea scoagulare a vita)

Classificazione
First diagnosed
Paroxysmal: che cessa entro 7 giorni
Persistent: tra i 7 gg e i 12 mesi
Long-standing persistent: >12 mesi
Permanent: non si cerca di farla passare
EHRA symptom scale
Score Symptoms Description
1 None AF does not cause any symptoms
2a Mild Normal daily activity not affected by symptoms related to AF
2b Moderate Normal daily activity not affected by symptoms related to AF, but patient troubled by symptoms

3 Severe Normal daily activity affected by symptoms related to AF
4 Disabling Normal daily activity discontinued

==========PRECEDENTI ==========