Ablation de la Fibrillation Atriale dans l'Insuffisance Cardiaq

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Déclaration de conflits d'intérêts

Aucun

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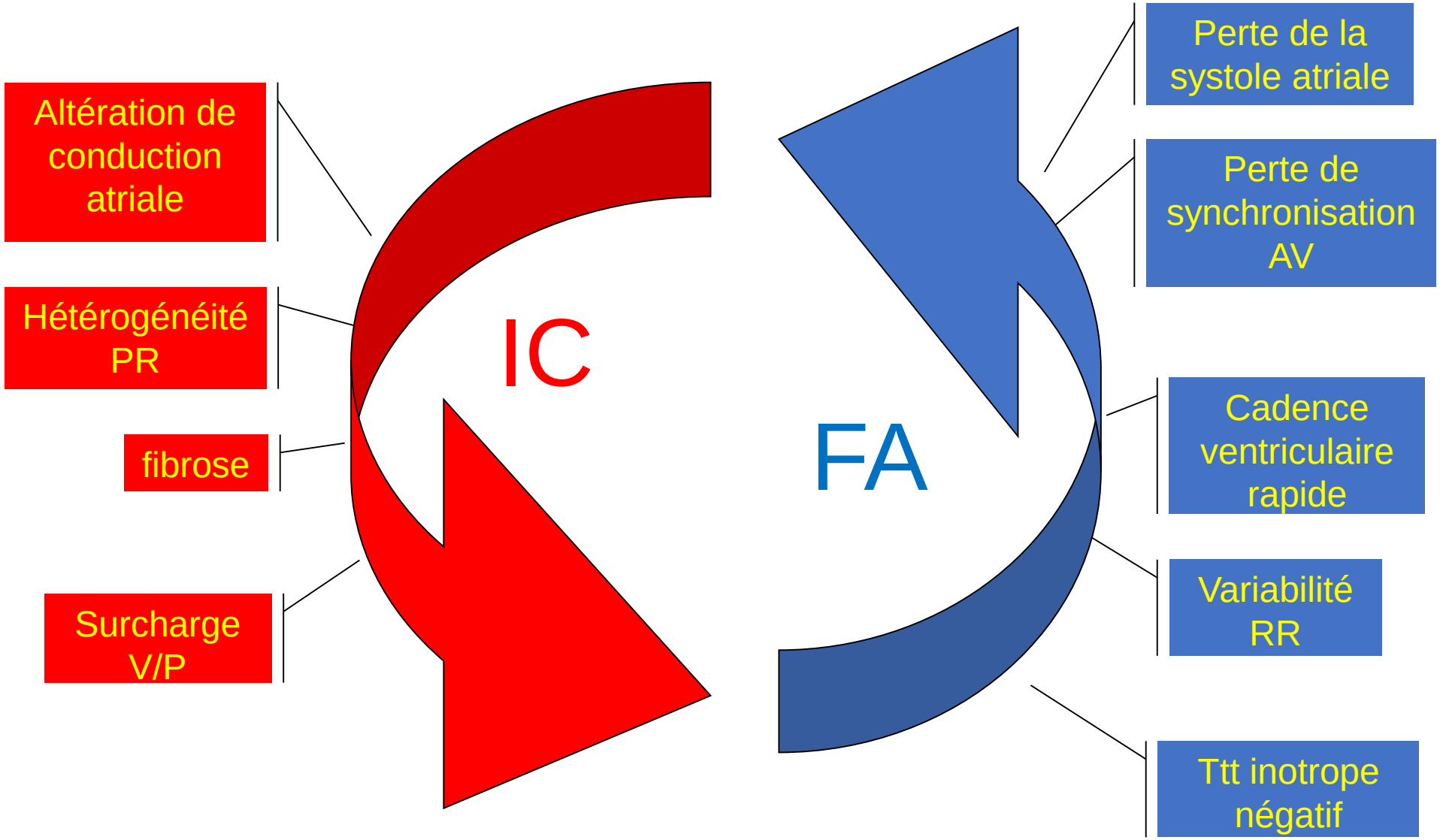
Société Tunisienne de Cardiologie & de Chirurgie Cardio-Vasculaire

Physiopathologie



Mr C.O. 66 ans

HTA , Dylipidemie

Insuffisance cardiaque sur OAP initial

FE 35%

Rythme sinusal QRS fin

Coronarographie: Tritronculaire

<u>Que faire en plus du ttt de l'ins. cardiaque?</u>

A: ttt medical (β-, Statine, Aspirine/DAPT…)

B: ttt medical + Revascularisation

C: Rien, ça va passer…

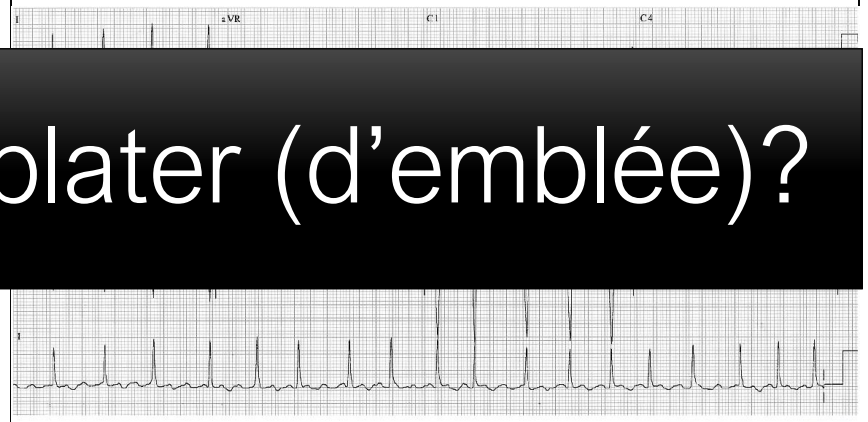
Mr A.R. 64 ans

HTA, Dylipidemie

Insuffisance cardiaque sur OAP initial

FE 35% Coronaires saines

ECG en FA QRS fins



<u>Que faire en plus du ttt de l'ins. cardiaque et de l'anticoagulation?</u>

A: ttt ralentisseur (bb/Digoxine)

B: Cardioversion et amiodarone

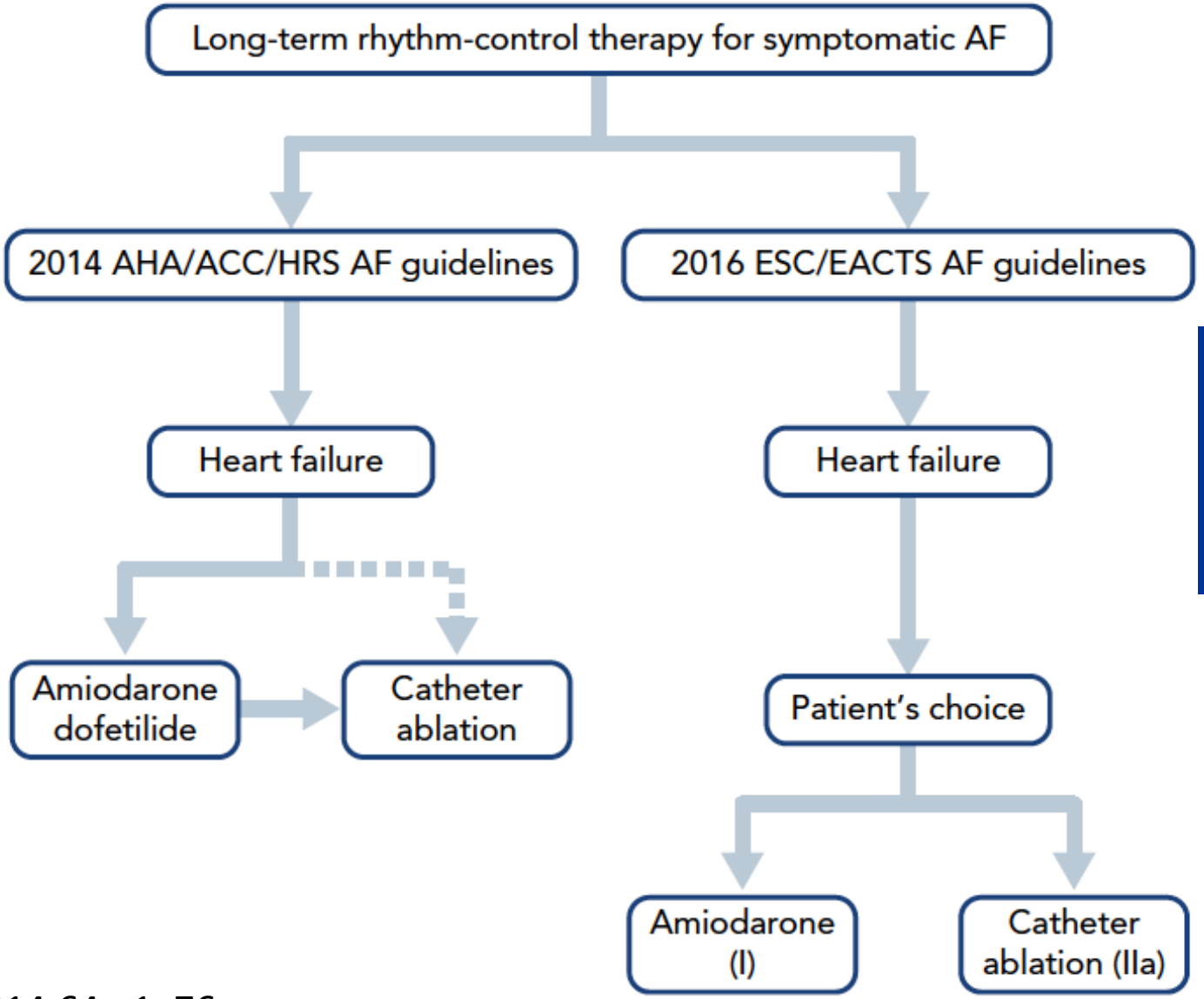
C: ablation d'emblée

D: Rien, ça va passer…

Pourquoi ne pas ablater (d'emblée)?


Parce que c’est complexe
Parce que ça ne marche pas
Parce que ça coute cher
Parce que c’est un problème d’ins Card
Pourquoi ne pas ablater (d’emblée)?
Parce que c’est dangereux
Parce qu’on a le temps de voir plus tard…
Parce que ce n’est pas recommandé!

Recommandations

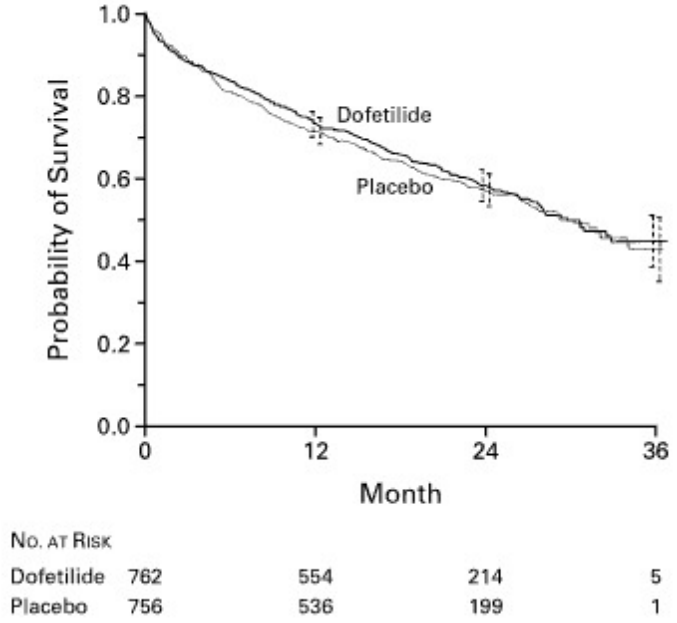


J Am Coll Cardiol 2014;64:e1–76

Europace 2016;18:1609–78

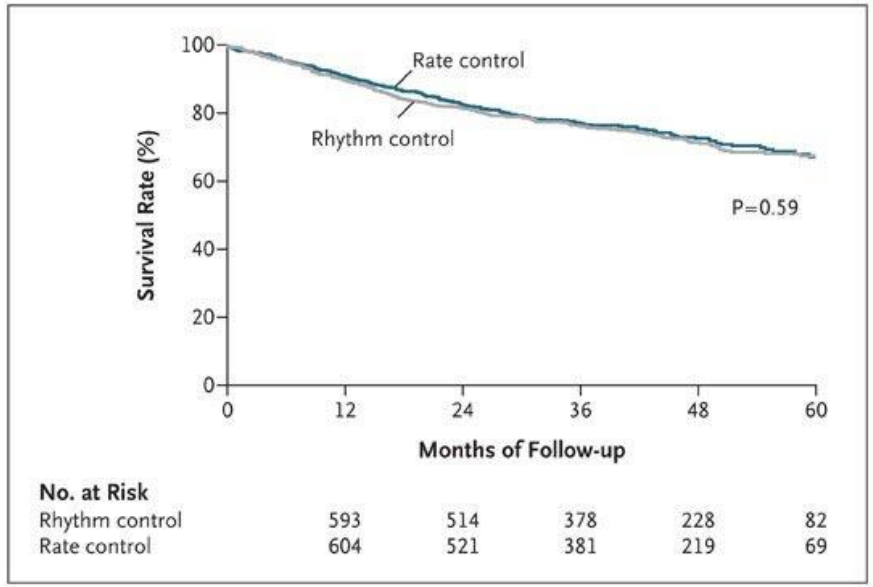
Pourquoi le rythme sinusal est si mal vu????

DIAMOND-CHF
1518 patients danois
FA et Ins Cardiaque III ou IV / FE<35%
Randomisé Dofetilide Vs Placebo



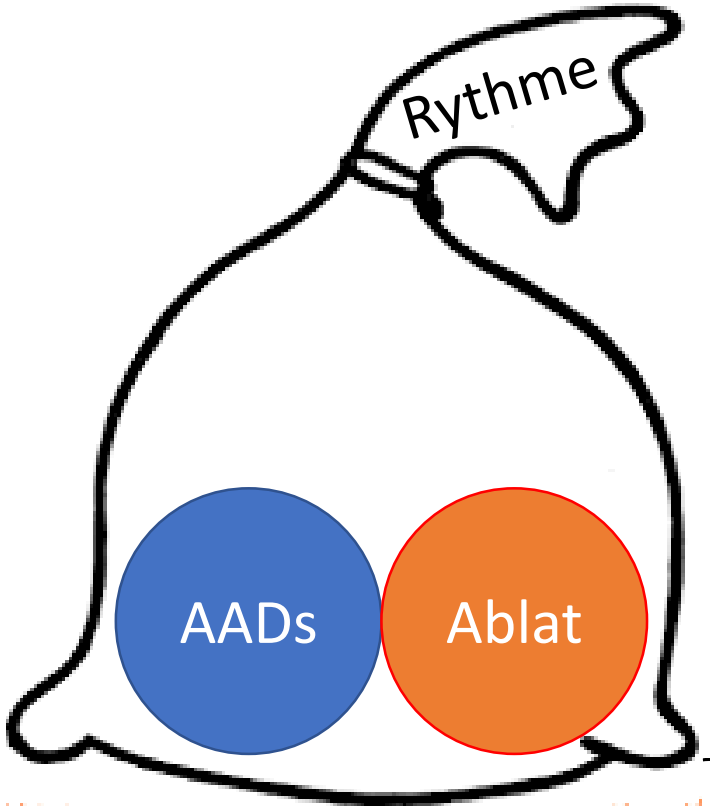
N Engl J Med 1999; 341:857-865

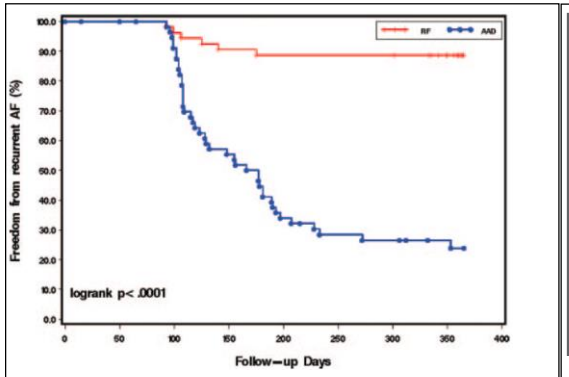
AF-CHF
1376 patients internationaux
FA et Ins Cardiaque II à IV / FE<35%
Randomisé Rate Vs Rhythm



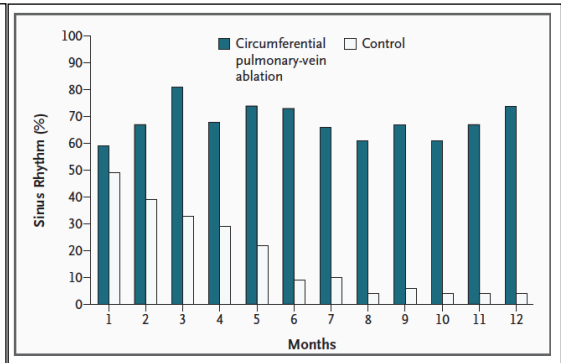
N Engl J Med 2008; 358:2667-2677

Pourquoi le rythme sinusal est si mal vu????

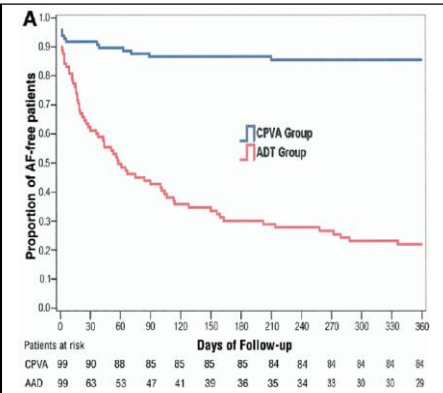




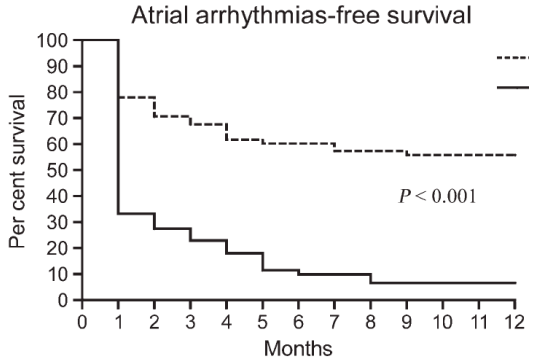
Circ 2008;118:2498-2505



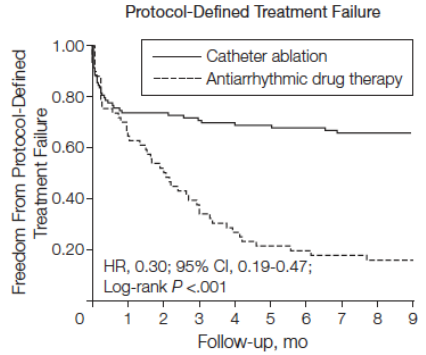
NEJM 2006;354:934-41.



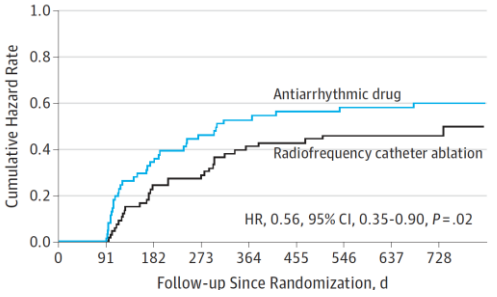
JACC Vol. 48, No. 11, 2006



EHJ (2006) 27, 216–221



JAMA 2010;303(4):333-340

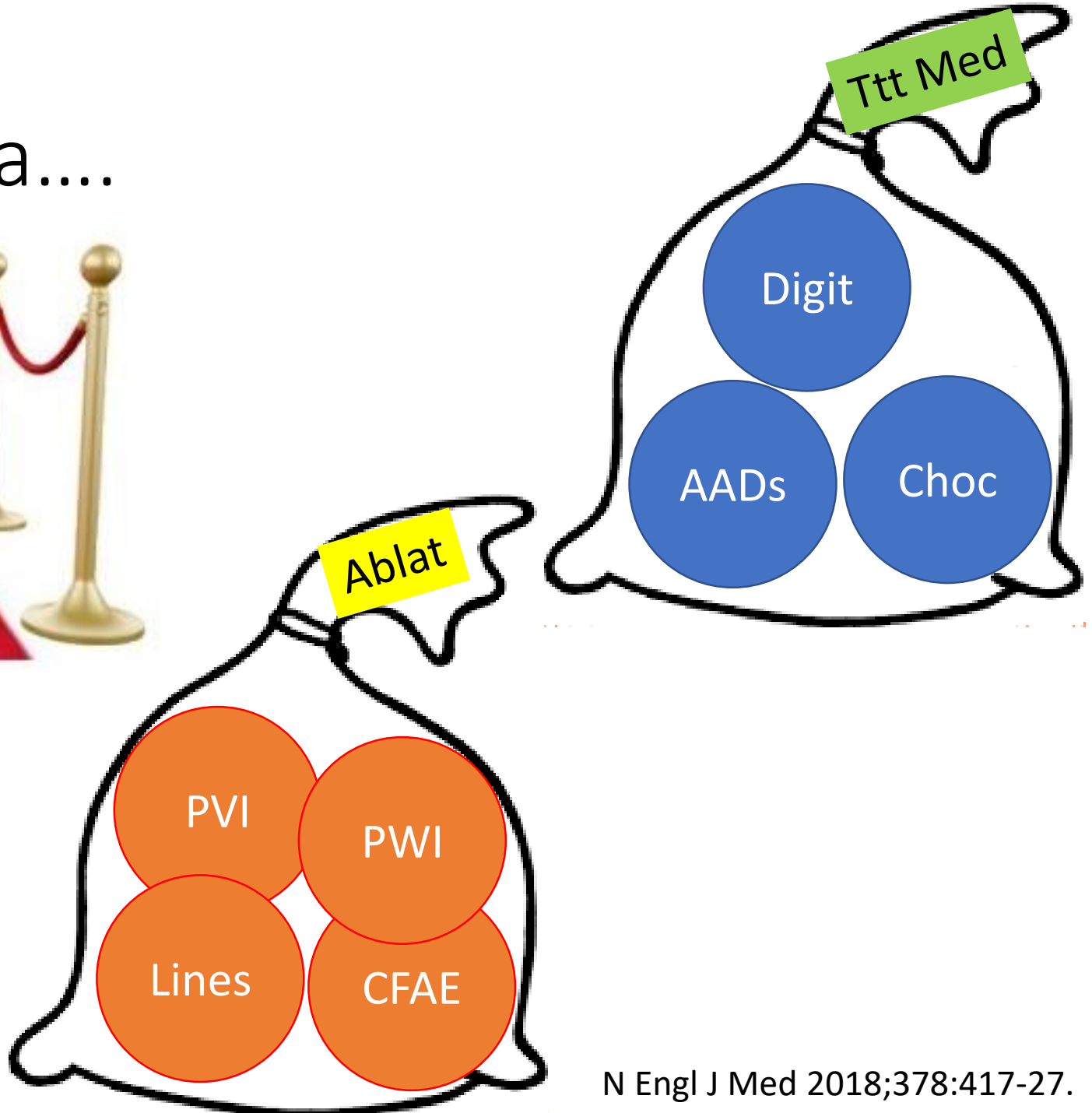


JAMA 2014;311(7):692-699

Historique de l'ablation de FA en IC

	2008	2013	2014	2016	2017	2018
	PABA-CHF	ARC-HF	CAMTAF	AATAC	CAMERA-MRI	
Technique	PVI	PVI±CFAEs ± Lines	PVI±CFAEs ± Lines	PVI±PWI± Lines	PVI±PWI	
Vs	AVN+biV	Rate Control	Rate Control	Amio	Rate Control	
Size	n=81	n=52	n=50	n=203	n=68	
f.u.	6 months	12 months	12 months	36 months	6 months	
Endpoints	EF/6MWT/ MLWHF	EF	VO_2	AF	EF	
Results	Ablation	No ≠	Ablation	Ablation	Ablation	

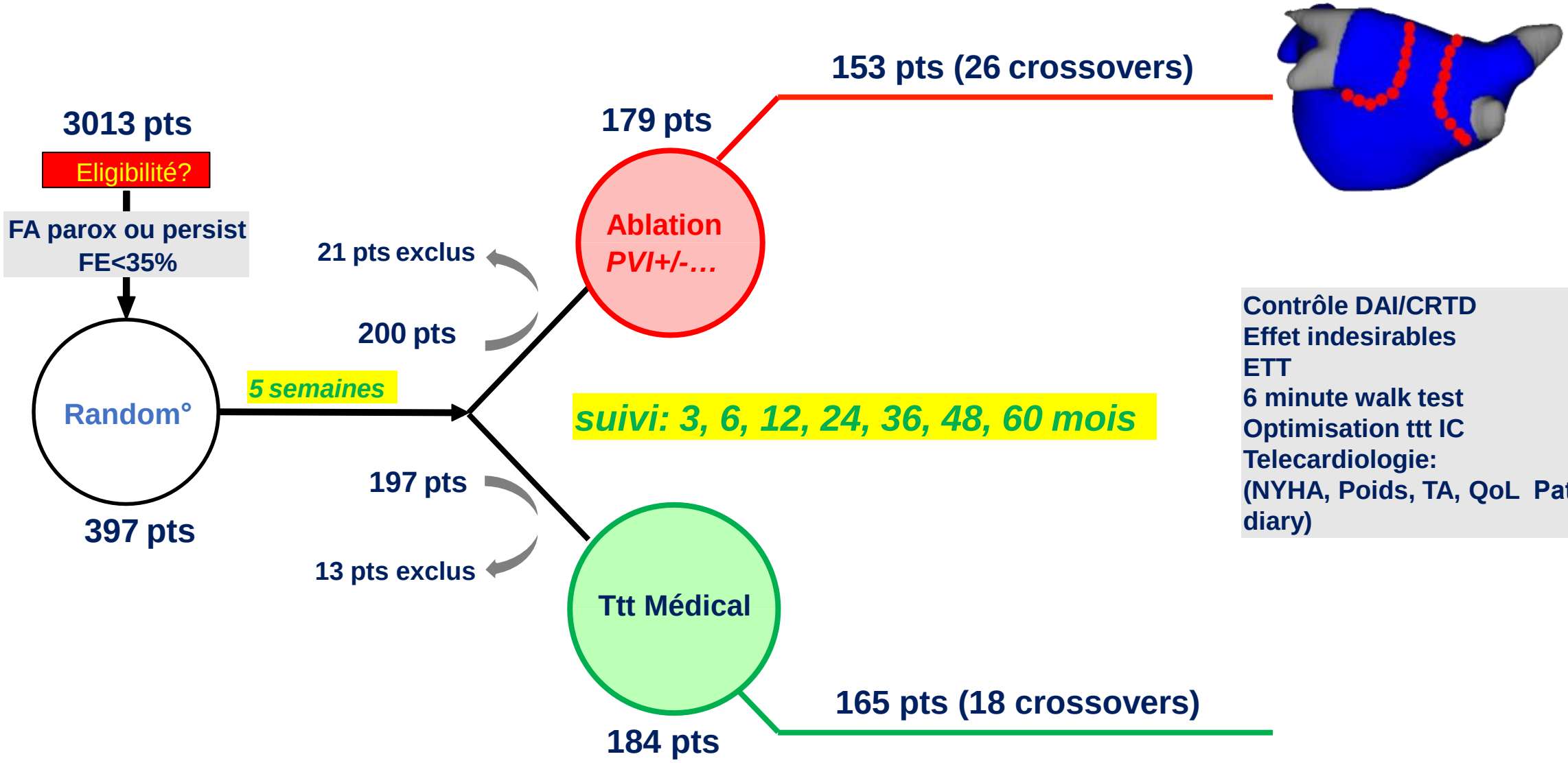
Et CASTLE-AF arriva....



N Engl J Med 2018;378:417-27.

Study Design— CASTLEAF

- **Essai thérapeutique contrôlé randomisé (31 sites, 9 pays),**



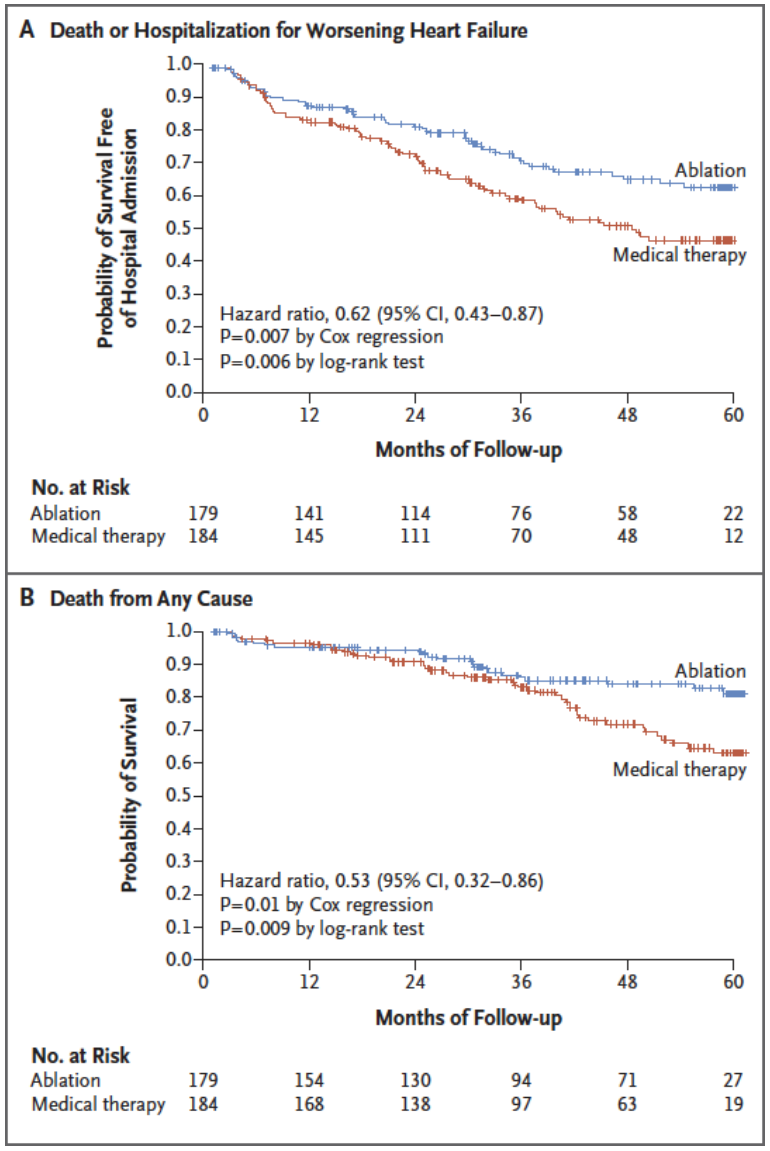
N Engl J Med 2018;378:417-27.

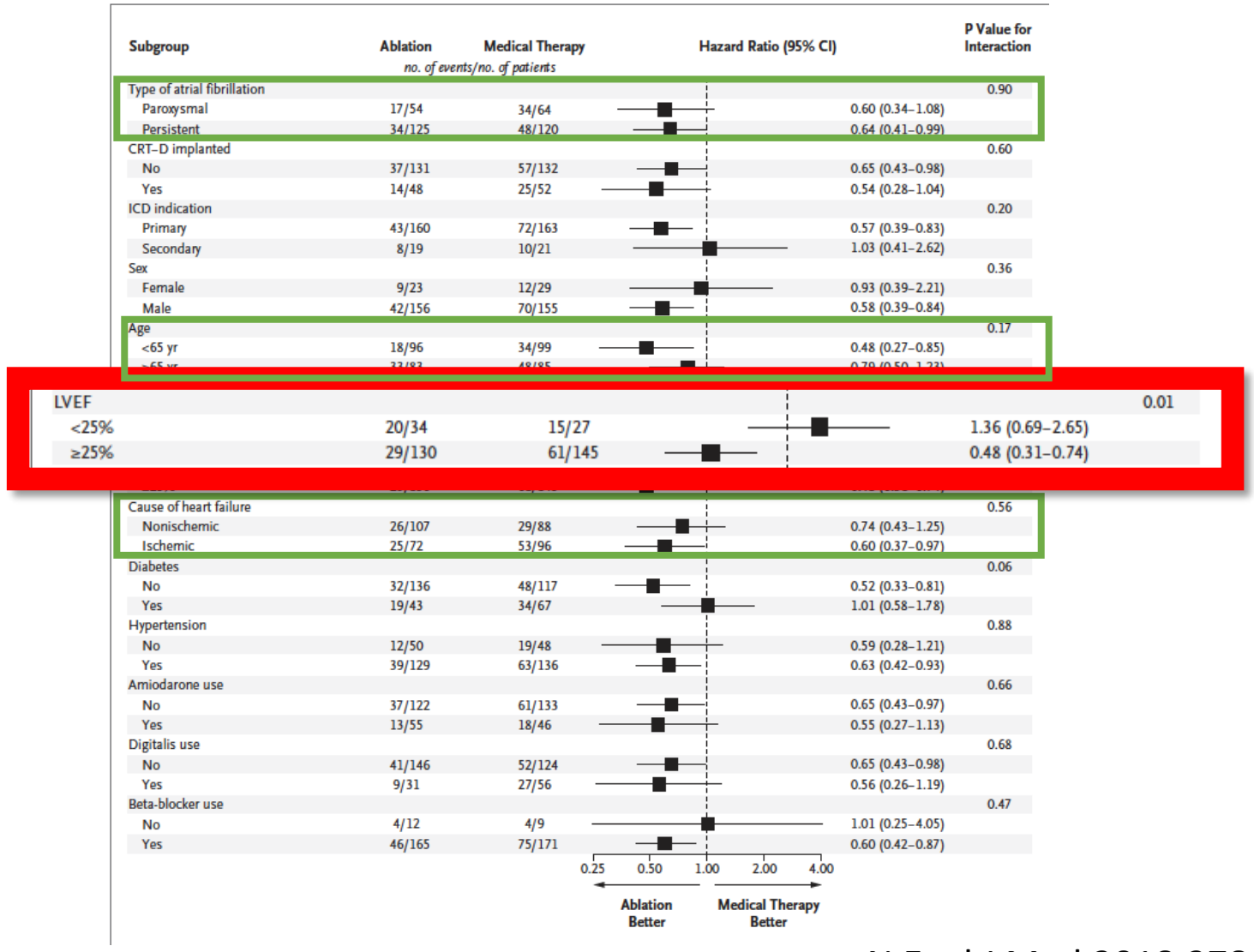
Patients CASTLE AF

	Ablation (179 patients)	Medical (184 patients)
Age – years	64 (5671)	64 (5673.5)
New York Heart Association class		
I (%)	11	11
II (%)	58	61
III (%)	29	27
IV (%)	2	1
Left ventricular ejection fraction – %	32.5 (25.038.0)	31.5 (27.037.0)
Left atrial diameter– mm	48	49.5
Current type of atrial fibrillation		
Paroxysmal (%)	**30**	**35**
Persistent (%)	**70**	**65**
Long standing Persistent (%)	**28**	**29**
CRTD implanted (%)	27	28

N Engl J Med 2018;378:417-27.

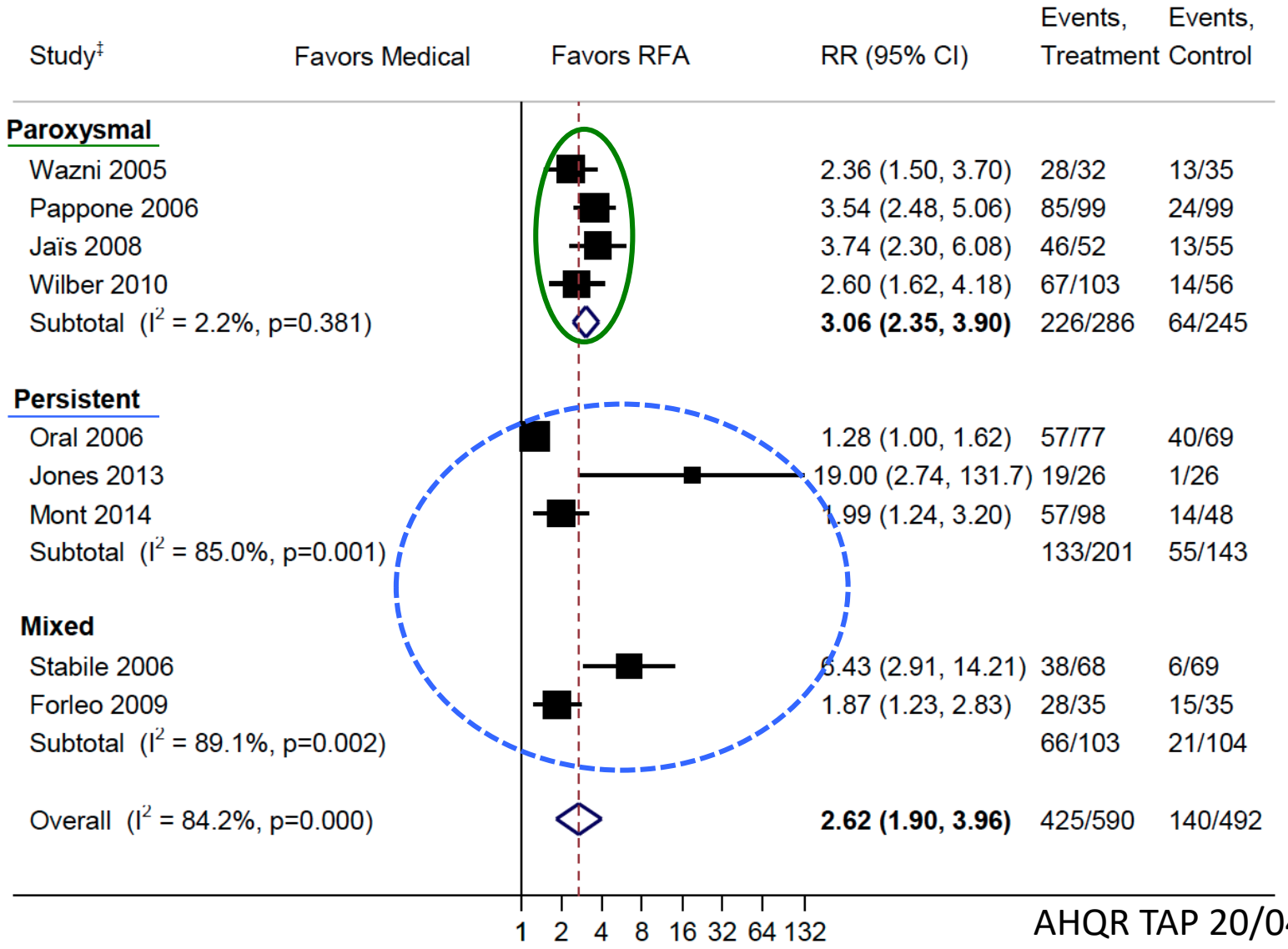
Castle AF Résultats





N Engl J Med 2018;378:417-27.

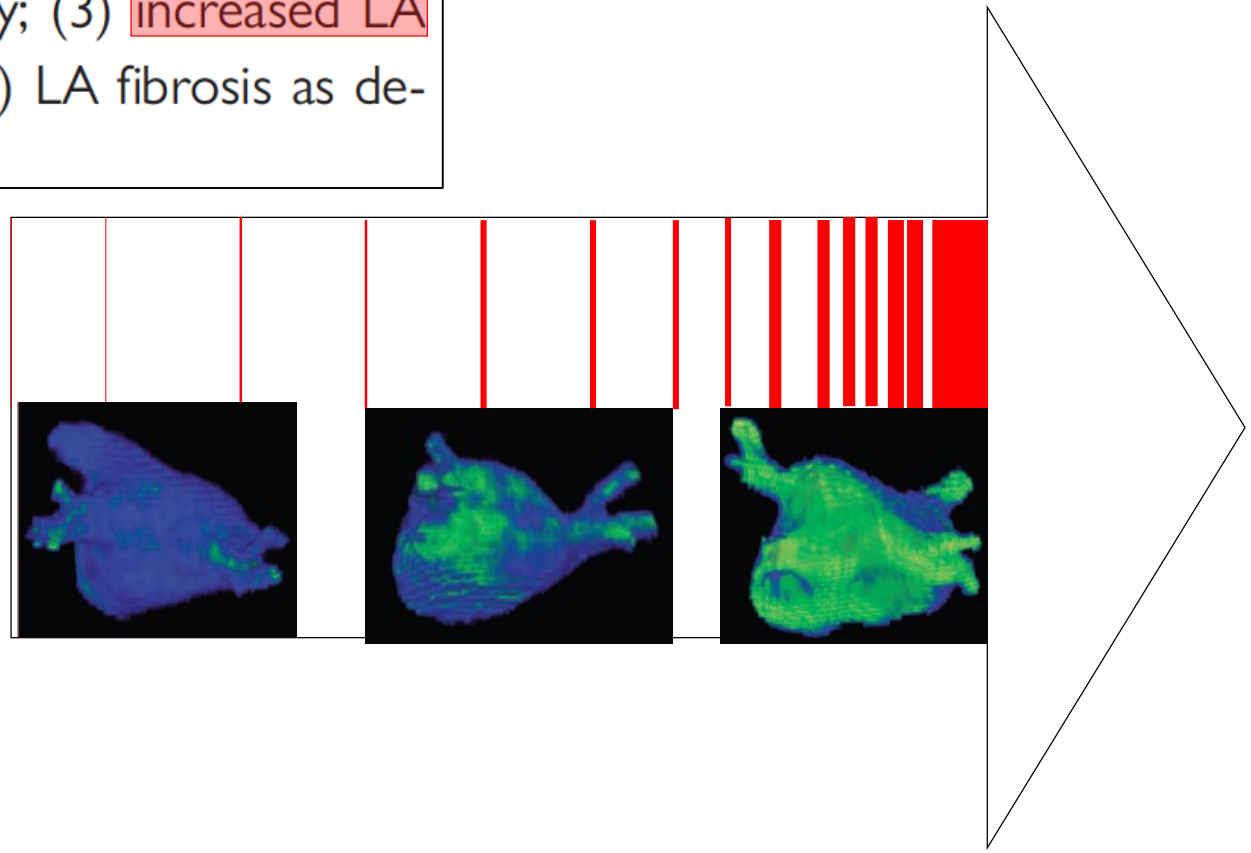
Discordances entre FA parox et peristante



AHQR TAP 20/04/2015

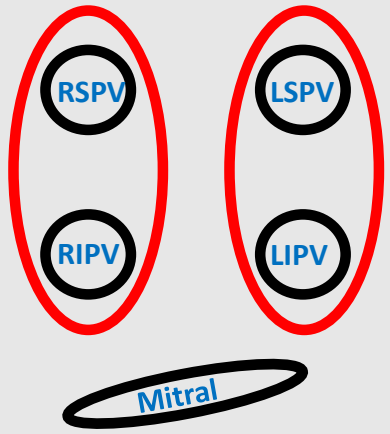
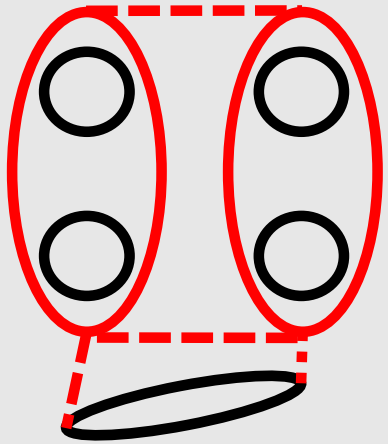
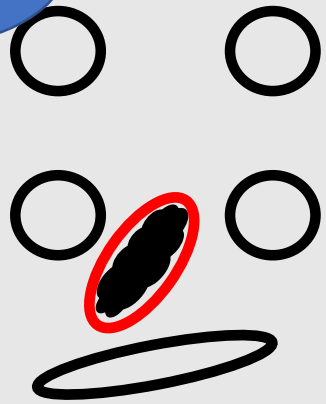
Deuxième regard vers les recommandations….

Factors that have been identified as predictors of a poorer outcome, at least in some studies, include (1) non-PAF and particularly long-term persistent AF; (2) sleep apnea and obesity; (3) increased LA size; (4) increased age; (5) hypertension; and (6) LA fibrosis as detected by cardiac MRI.[365]



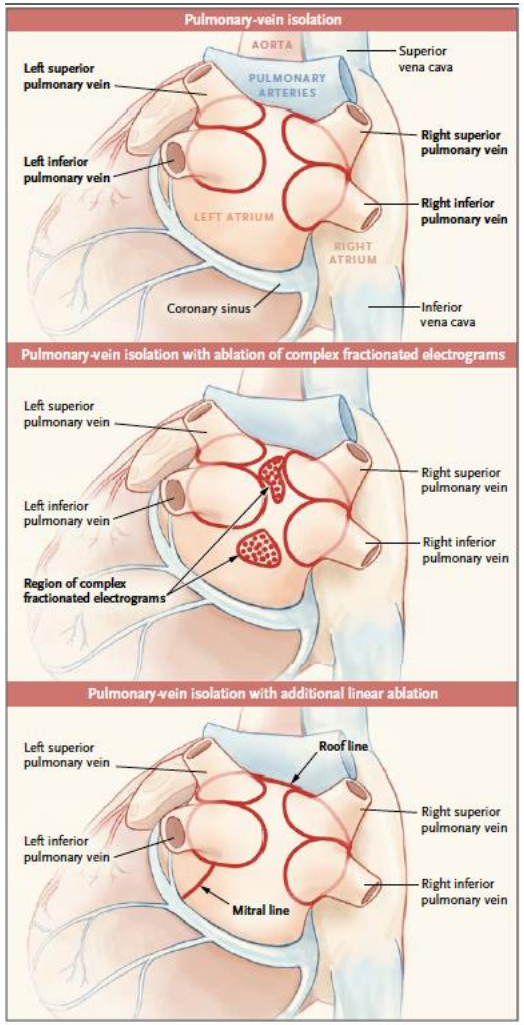
Europace (2017) 00, 1–160

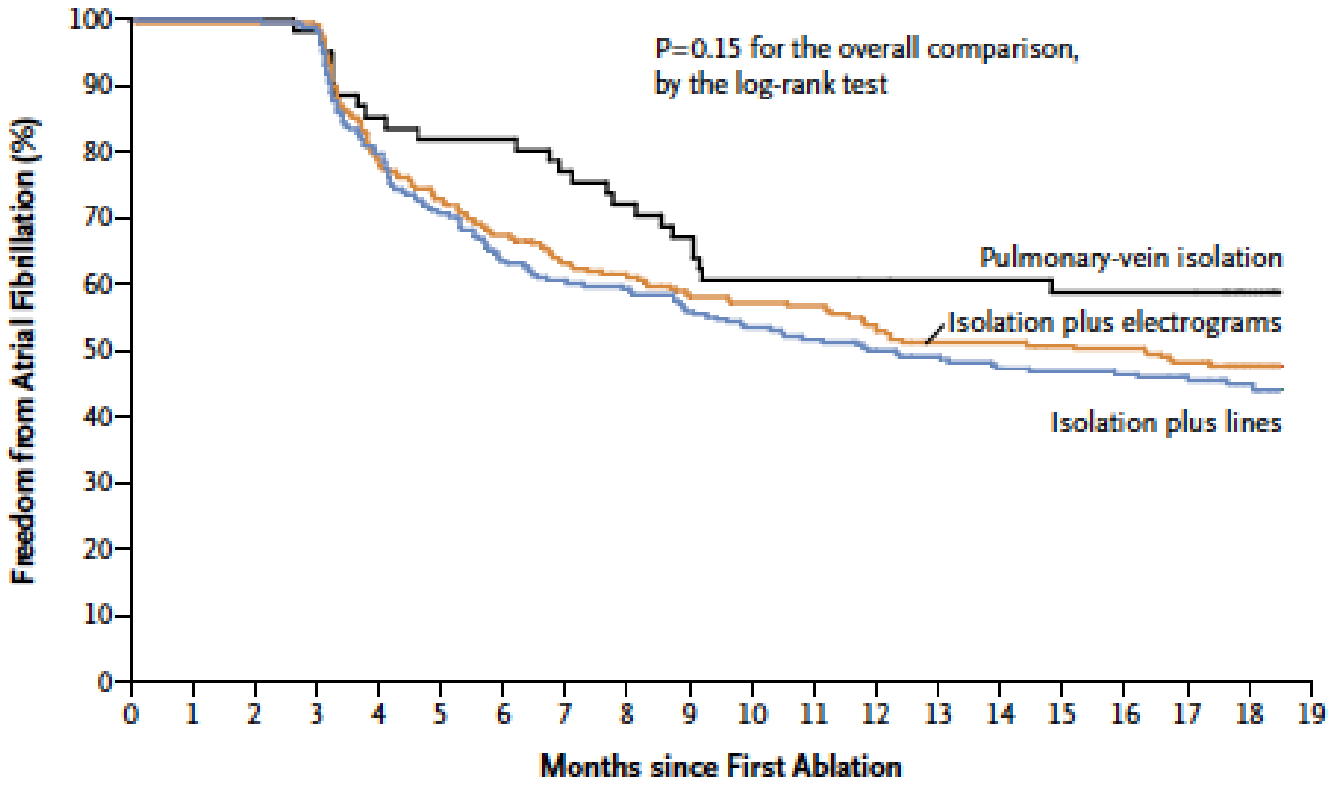
Comment ablater la FA persistante?

PAF	(LS)PsAF		
PVI	Lines	CFA	BIFA
			
AntalPV Block	AF Conversion? SR?		

Interresting but non reproducible

Mauvaises nouvelles pour la FA persistante





No. at Risk

Pulmonary-vein isolation	61	60	50	41	36	23
Isolation plus electrograms	244	242	161	137	124	72
Isolation plus lines	244	240	152	133	115	57

N Engl J Med 2015;372:1812-22

Mauvaises nouvelles pour la FA persistante

Technique	Class-LOE
Isolation VP	I-A
Ablation flutter concomittant	I-B
Lignes	**IIb-C**
Isolation du mur posterieur	**IIb-C**
Domain Frequency Ablation	IIb-C
Ablation BIFA	IIb-B
Ablation CFAEs	IIb-B
Ablation de rotors	IIb-B
Ablation ganglions	IIb-B

Europace (2017) 00, 1–160

Malgré STAR-AF 2, les experts continuent à…

tion during repeat procedures. Ten percent of the writing group members routinely employ CFAE-based ablation as part of an initial ablation strategy in patients with persistent and long-standing persistent AF, and 26% incorporate CFAE-based ablation for redo procedures in this subset of patients. Based on this information and a review

defragmenter(10-25%)…

Isoler le mur posterieur(20-40%)

AF also remains controversial.[508] For patients with persistent or long-standing persistent AF, 22% of the writing group members perform posterior wall isolation at the time of an initial AF ablation procedure and 38% of the writing group members perform posterior wall isolation for repeat AF ablation procedures in patients with persistent and long-standing persistent AF. Based on this information and

alone.[509] For patients with persistent or long-standing persistent AF, 25% of the writing group members perform linear ablation at the time of an initial ablation procedure, increasing to 45% when redo procedures are performed in patients with persistent and long-standing persistent AF. The writing group recognizes that the usefulness of linear ablation lesions in the absence of macroreentrant AFL is not well established (Class IIb, LOE C-LD). For patients with PAF,

Faire des lignes(25-45%)

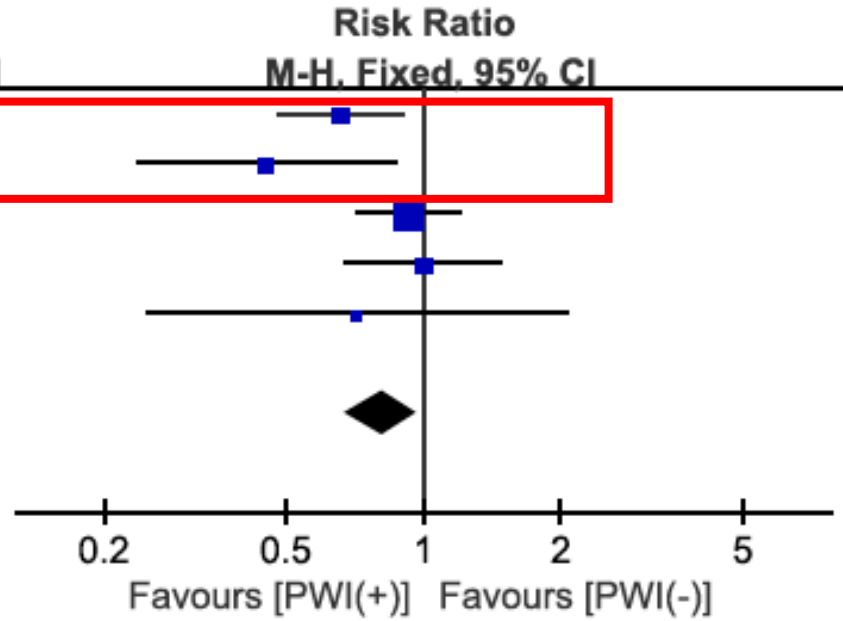
Europace (2017) 00, 1–160

L’isolation du mur posterieur (PWI ou Box)

Metaanalyse de 5 études
594 patients

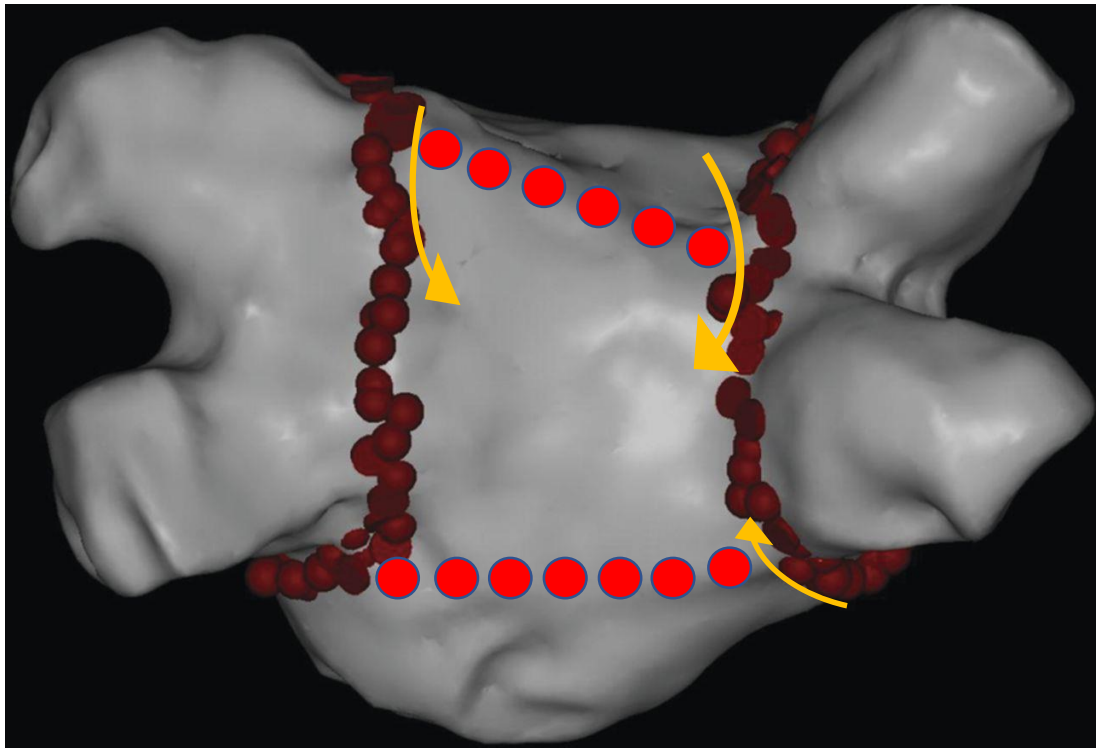
Study or Subgroup	PWI(+) Events	Total	PWI(-) Events	Total	Weight	Risk Ratio M-H, Fixed, 95% CI
Bai et al 2015	19	32	18	20	16.4%	0.66 [0.48, 0.91]
Kim et al 2015	10	60	22	60	16.3%	0.45 [0.24, 0.88]
Lim et al 2012	53	110	57	110	42.2%	0.93 [0.71, 1.21]
Tamborero et al 2009	27	60	27	60	20.0%	1.00 [0.67, 1.49]
Thomas et al 2007	5	41	7	41	5.2%	0.71 [0.25, 2.07]
Total (95% CI)		**303**		**291**	**100.0%**	**0.81 [0.68, 0.97]**
Total events	114		131			

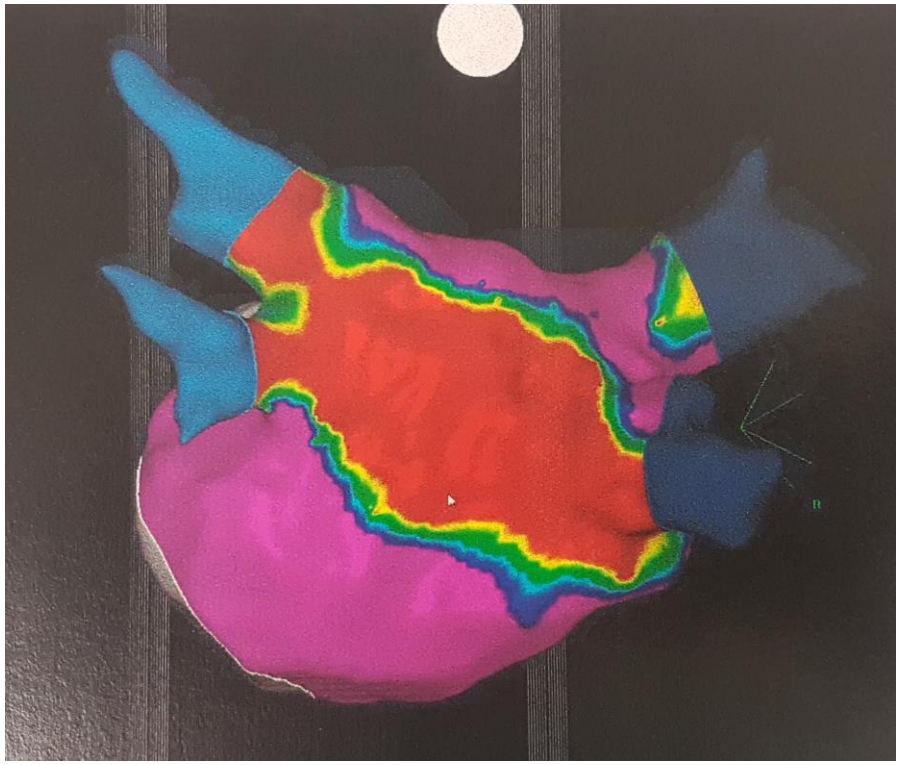
Heterogeneity: Chi² = 6.73, df = 4 (P = 0.15); I² = 41%
Test for overall effect: Z = 2.25 (P = 0.02)



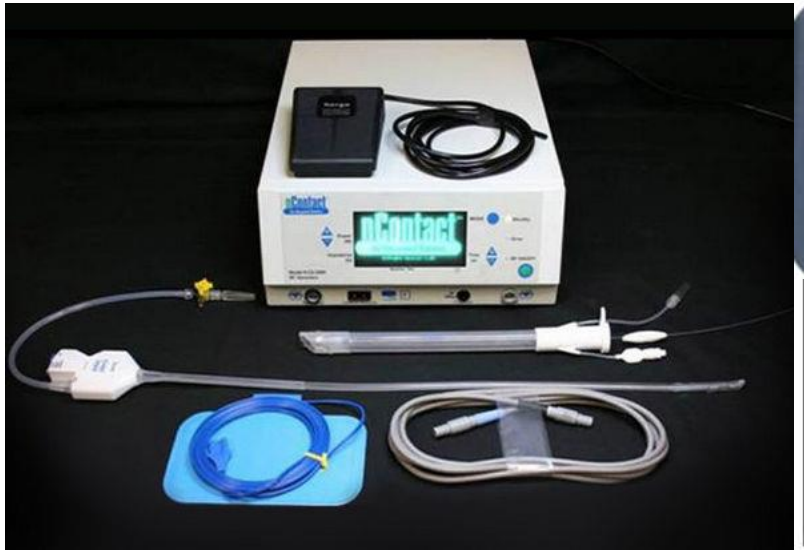
J Interv Card Electrophysiol (2016) 46:267–274

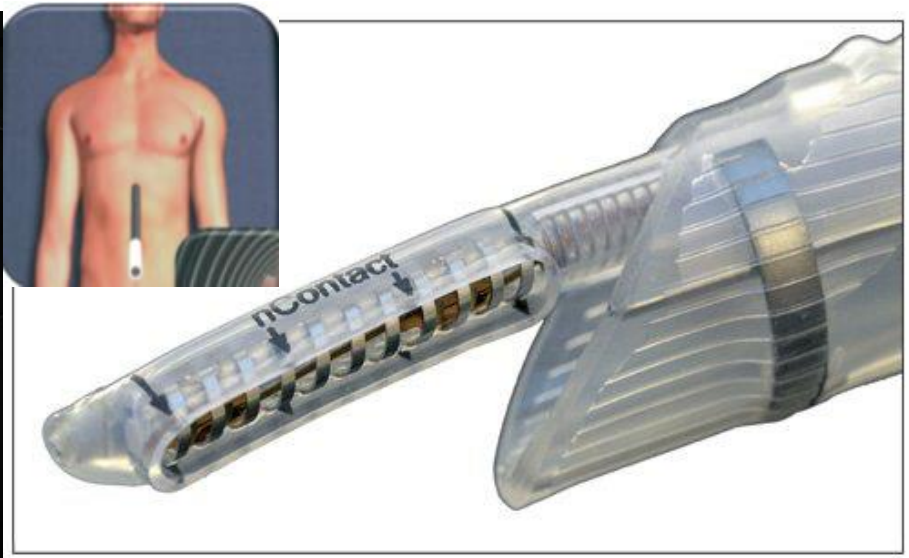
L’isolation du mur postérieur peut etre difficile dans la FA persistante avec des OG de gros volumes

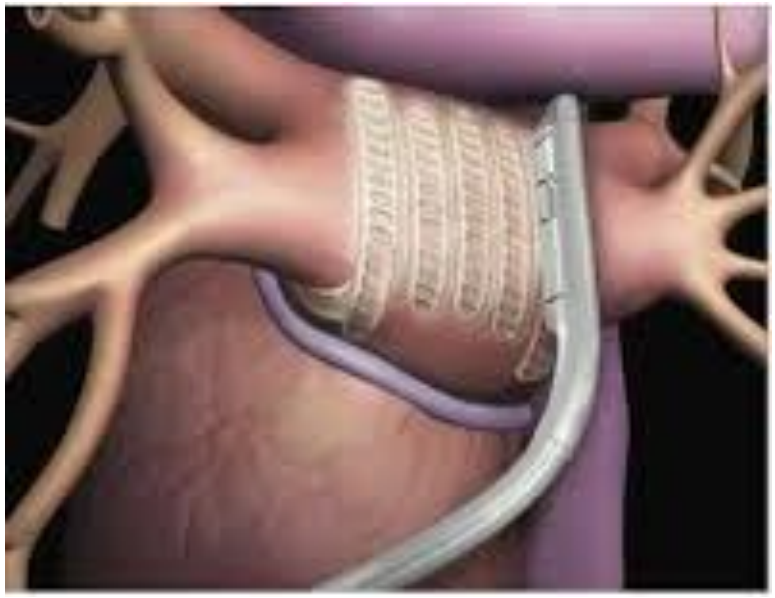




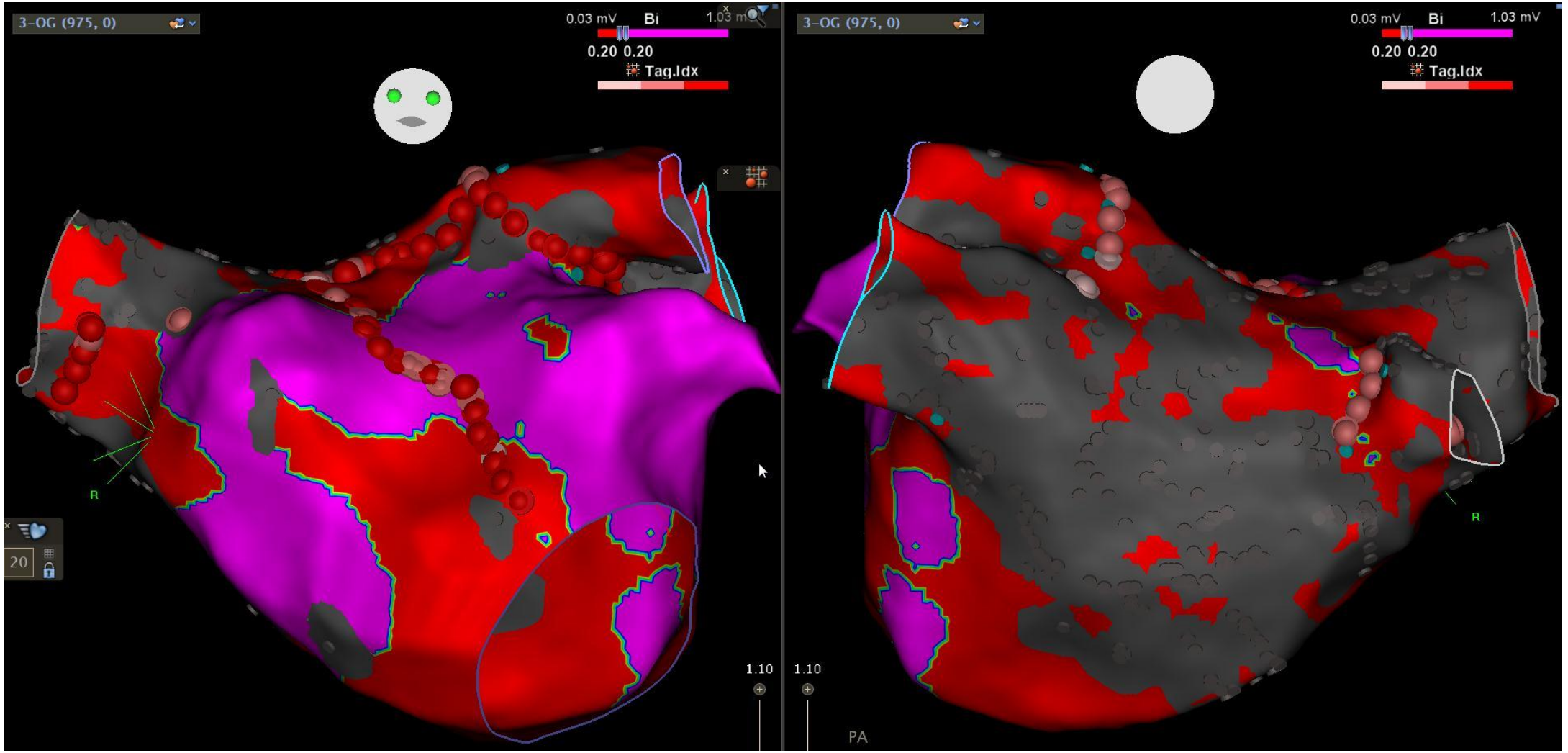
Ablation mur postérieur OG épicardique
Approche hybride





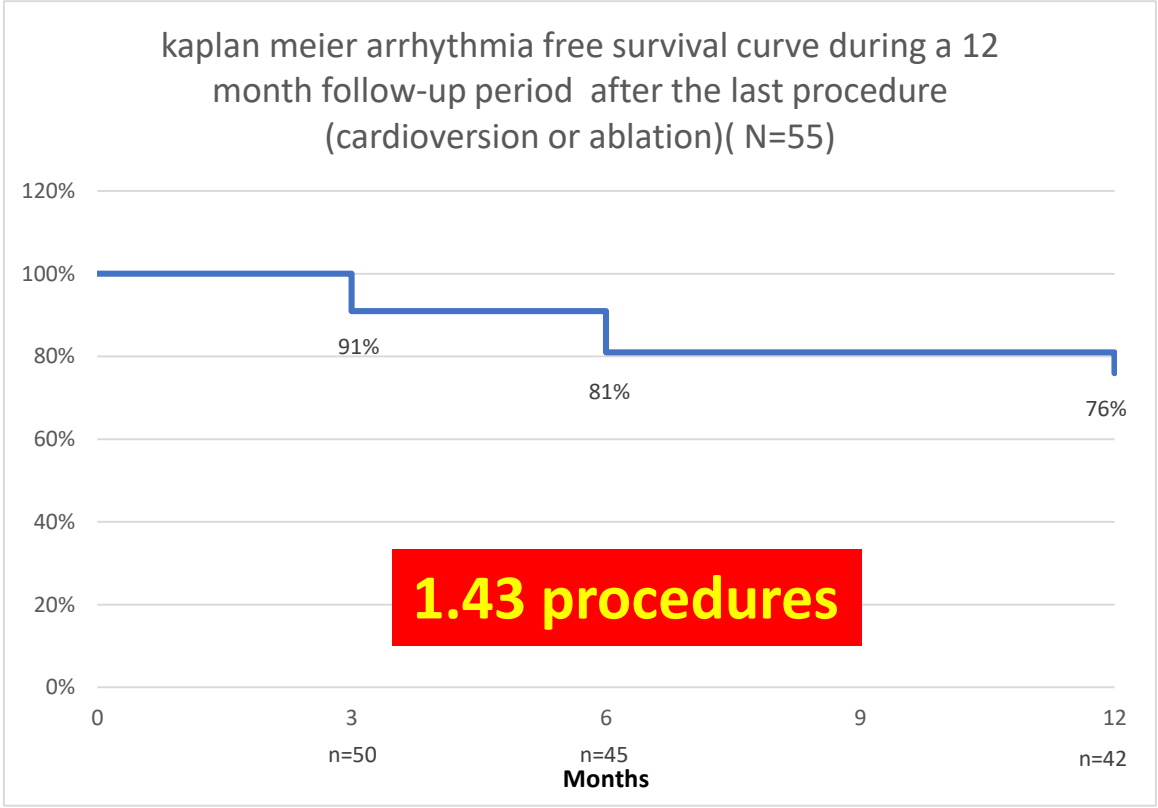


Ablation mur postérieur OG épicardique
Approche hybride



Notre experience

- 55 patients FA persistante longue durée
- Diametre OG moyen: 47mm
- Ancienneté de FA: 7 ans
- Durée de FA: 14 mois
- **Insuffisance cardiaque 72%**
- **Env. 2.5 echecs de procedure endo**
- IMM/Mondor
- Suivi 1 an(Holter à 6 -12 mois)



En conclusion

- Il faut proposer une ablation de FA aux insuffisants cardiaques
  - Sauf FE <25%
  - Chez des patients plutôt jeunes
- Décloisonner l'ablation des stratégies médicamenteuses de contrôle du rythme
- Ablation (intellectuellement) difficile
  - Le plus souvent FA persistante
  - Approche hybride interressante

CoSAC
Le congrès des
Sociétés Africaines
de Cardiologie

STCCCV
Société Tunisienne
de Cardiologie & de Chirurgie
Cardio-Vasculaire