

## 2004 Canadian Cardiovascular Society Consensus Conference: Atrial Fibrillation

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### BACKGROUND AND CONSENSUS PROCESS

Atrial fibrillation (AF) affects approximately 200,000 to 250,000 Canadians and is associated with many common clinical conditions such as aging, thromboembolism, hypertension, valvular heart disease and heart failure. In Canada, AF is likewise responsible for substantial morbidity and increased mortality. Increased mortality rates are mainly due to strokes, with AF being a major independent risk factor (up to 15% of all strokes are due to AF). Even still, the clinical impact of AF is probably underestimated because this arrhythmia is frequently asymptomatic and can be the unrecognized cause of complications such as precipitated heart failure or stroke. Consequently, AF places a tremendous burden on our health care resources. Therefore, the management of AF is complex and has far-ranging implications that make it an important challenge for treating physicians.

### WHY UPDATE THE AF CONSENSUS CONFERENCE?

AF was the topic of the 1994 Consensus Conference of the Canadian Cardiovascular Society (CCS). The subsequent

publication of the Consensus in the January 1996 issue of *The Canadian Journal of Cardiology* provided the first North American recommendations regarding the management of AF (1). At the time, however, the Chair of the Consensus initiative, Charles R Kerr, indicated in his introductory remarks that many of the recommendations were based on clinical judgement with little firm scientific evidence.

In the intervening decade, much of our knowledge about the management of AF has been solidified or modified by the enormous amount of research being performed on this disease. Unfortunately, many issues remain for which there is little or no scientific evidence to guide clinical practice. Other organizations have reported practice guidelines on AF, the most recent and comprehensive of which was from the 2001 American College of Cardiology/American Heart Association/European Society of Cardiology Board Task Force (2), but the CCS thought it worthwhile to revisit the topic for two important reasons. First, since the publication of the 2001 Task Force report, a number of major randomized clinical trials on the subject have been completed, and as will be evident in the ensuing papers, Canadian physicians, researchers, nurses and patients

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have been at the forefront of these studies. Second, Canadian practices for dealing with AF differ somewhat from those of our American and European counterparts, particularly in areas such as antiarrhythmic drug use, health care access and costs.

The present Consensus Conference was developed to incorporate these new data and to update AF practice recommendations in the context of Canadian standards of practice and the Canadian health care system.

### ORGANIZATION OF THE CONSENSUS

Following a recommendation of the CCS Consensus Conference Committee, the cochairs were appointed by council in June 2003 and, subsequently, they identified the 16 clinical and scientific experts of the primary panel. Major areas of interest were selected and assigned to the experts on the panel. The primary panelists prepared documents that were circulated, and recommendations were then debated, revised and voted on during a face-to-face meeting in February 2004. A secondary panel of physicians, cardiologists and arrhythmia experts reviewed the manuscripts during the spring of 2004. Following these revisions, the documents were then reviewed by the entire CCS membership through e-mails and postings on the CCS Web site. The final text and recommendations were presented at the Annual Meeting of the Canadian Cardiovascular Congress in Calgary, Alberta, in October 2004.

### RECOMMENDATIONS AND RULES OF EVIDENCE

Recommendations are expressed in the standard American College of Cardiology/American Heart Association/European Society of Cardiology Board format:

**Class I:** Conditions for which there is evidence for and/or general agreement that the procedure or treatment is useful and effective.

**Class II:** Conditions for which there is conflicting evidence

and/or a divergence of opinion about the usefulness/efficacy of a procedure or treatment.

**Class IIa:** The weight of evidence or opinion is in favour of the procedure or treatment.

**Class IIb:** Usefulness/efficacy is less well established by evidence or opinion.

**Class III:** Conditions for which there is evidence and/or general agreement that the procedure or treatment is not useful/effective and in some cases may be harmful.

Evidence supporting the recommendations is ranked as:

**A (highest):** When the data were derived from multiple randomized clinical trials involving a large number of individuals.

**B (intermediate):** When the data were derived from a limited number of randomized trials, nonrandomized studies or observational registries.

**C (lowest):** When the primary basis for the recommendation was expert consensus.

### REFERENCES

1. Canadian Cardiovascular Society Consensus Conference on Atrial Fibrillation. *Can J Cardiol* 1996;12(Suppl A):1A-61A.
2. Fuster V, Ryden LE, Asinger RW, et al; American College of Cardiology/American Heart Association/European Society of Cardiology Board. ACC/AHA/ESC guidelines for the management of patients with atrial fibrillation: Executive summary. A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the European Society of Cardiology Committee for Practice Guidelines and Policy Conferences (Committee to Develop Guidelines for the Management of Patients With Atrial Fibrillation): Developed in collaboration with the North American Society of Pacing and Electrophysiology. *J Am Coll Cardiol* 2001;38:1231-66.

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These recommendations reflect emerging clinical and scientific advances as of the date issued and are subject to change. These consensus conference statements are intended to assist practitioners in clinical decision-making by describing a range of generally acceptable approaches for the diagnosis, management, or prevention of specific diseases or conditions. The information is not to be construed as dictating an exclusive course of treatment or procedure to be followed and variations may be appropriate. Each cardiovascular specialist must exercise his or her own professional judgment in determining the proper course of action in each patient's differing circumstances. The CCS assumes no responsibility or liability arising from any error or omission in or from the use of any information contained herein.