AF

AF FOCUSED UPDATE: 2014-2019 COMPARISON TOOL

Based on the 2019 AHA/ACC/HRS Focused Update of the 2014 Guideline for the Management of Patients with Atrial Fibrillation.

Use this tool to recognize new and updated recommendations from the AF Focused Update.

Change in Guideline Recommendations (Only major included)	
2014	**2019**
The term *"nonvalvular AF"* is no longer used	
Section 4.1.1 - Selection of Antithrombotic Regimen	
Oral anticoagulants recommended for high risk patients **now include edoxaban.**	
Exclusion criteria for CHA$_2$DS$_2$-VASc assessment and use of NOACs **now defined as moderate to severe mitral stenosis or a mechanical heart valve.**	
For patients with AF and end-stage chronic kidney disease, the direct thrombin inhibitor dabigatran, or the factor Xa inhibitors rivaroxaban **OR edoxaban** are not recommended.	
Section 6.1.1 - Prevention of Thromboembolism	
For patients with AF or atrial flutter of 48 hours' duration or longer, or when the duration of AF is unknown, anticoagulation with warfarin (INR 2.0 to 3.0), a factor Xa inhibitor, or direct thrombin inhibitor is recommended for at least 3 weeks before and at least 4 weeks after cardioversion.	→ **Upgraded to Class I Recommendation**
For patients with AF or atrial flutter of <48 hours' duration with a CHA$_2$DS$_2$-VASc score of ≥2 in men and ≥3 in women, administration of heparin, a factor Xa inhibitor, or a direct thrombin inhibitor is reasonable as soon as possible before cardioversion, followed by long term anticoagulation therapy.	→ **Downgraded to Class IIa Recommendation**

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New Recommendations
Section 4.1.1 - Selection of Antithrombotic Regimen
NOACs are recommended over warfarin where eligible except in those patients with moderate - severe mitral stenosis or a mechanical heart valve.
Section 4.3 - Interruption and Bridging Anticoagulation
Idarucizumab is the reversal agent for dabigatran in the event of life-threatening bleeding or an urgent procedure.
Andexanet Alfa is the reversal agent for apixaban and rivaroxaban.
Section 4.4.1 - Percutaneous Approaches to Occlude the Left Atrial Appendage
Percutaneous LAAO should be considered for those AF patients at an increased risk of stroke who have contraindications to long-term anticoagulation and who are at high risk of thromboembolic events.
Section 6.3.4 - Catheter Ablation in HF
Catheter ablation of AF is reasonable in symptomatic AF patients with HF and reduced LVEF.
Section 7.4 - Complicating Acute Coronary Syndrome
If triple therapy is prescribed post-stent placement, clopidogrel is preferred over prasugrel.
Double therapy with a $P2Y_{12}$ inhibitor and dose adjusted vitamin K antagonist is reasonable post-stenting.
Double therapy with clopidogrel and low-dose rivaroxaban (15 mg daily) may be reasonable post-stenting.
Double therapy with a $P2Y_{12}$ inhibitor and dabigatran 150 mg twice daily is reasonable post-stenting.
If triple therapy is prescribed for patients with AF who are at increased risk of stroke and who have undergone PCI with stenting for ACS, a transition to double therapy at 4-6 weeks may be considered.
Section 7.12 - Device Detection of AF and Atrial Flutter
In patients with cardiac implantable electronic devices, atrial high rate episodes (AHREs) should prompt further evaluation.
In patients with cryptogenic stroke in whom long-term external ambulatory monitoring is inconclusive implantation of a cardiac monitor is reasonable to detect silent AF.
Section 7.13 - Weight Loss
Weight loss and risk factor modification is recommended for overweight/obese patients with AF.

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