Rhythm Control Better for Paroxysmal Atrial Fib

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DENVER — A pharmacologic rhythm control strategy offers compelling advantages over rate control in patients with paroxysmal atrial fibrillation, according to the findings of the largest-ever randomized trial in such patients.

Results of this randomized, controlled trial of rhythm vs. rate control in Japanese patients, the Japanese Rhythm Management Trial for Atrial Fibrillation (J-RHYTHM) study, differ from the earlier Atrial Fibrillation Follow-up Investigation of Rhythm Management (AFFIRM) and Rate Control vs. Electrical Cardioversion (RACE) trials, which concluded that rhythm control is not superior and that rate control may be preferable. But it must be stressed that AFFIRM and RACE predominantly involved those with persistent AF, a different segment of the atrial fibrillation (AF) patient population, Dr. Satoshi Ogawa said at the annual meeting of the Heart Rhythm Society.

J-RHYTHM studied a population that differed from those in the earlier studies in other important ways. J-RHYTHM participants were younger—a mean age of 64 years, compared with 70 years in AFFIRM—and they didn't have access to amiodarone for rhythm control, as the drug isn't widely used in Japan, explained Dr. Ogawa of Keio University Hospital, Tokyo.

J-RHYTHM involved 819 patients with paroxysmal and 163 with persistent AF; separate analyses were performed for each group. The rhythm control strategy emphasized sodium channel–blocking antiarrhythmic agents such as flecainide and propafenone, because most patients had a normal left ventricular ejection fraction.

More than 80% of paroxysmal AF patients assigned to rhythm control maintained sinus rhythm at 2.5 years, as did slightly more than 50% in the persistent AF group.

The primary study end point was a composite of all-cause mortality, symptomatic cerebral infarction, systemic embolism, major bleeding, hospitalization for heart failure, and quality of life when AF-related physical and/or mental disability required discontinuation of the assigned strategy.

During a mean 586-day follow-up in the paroxysmal AF group, the composite end point occurred in 14.6% of patients in the rhythm control arm, a significantly lower rate than the 21.8% with rate control. This difference was entirely due to the reduced incidence of the disability end point, which occurred in 10.5% of the rhythm, compared with 16.3% of the rate, control group. The incidence of the other components of the composite end point was similar with rate and rhythm control.

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Disabilities resulting in discontinuation of the assigned AF management strategy mostly took the form of uncontrollable symptoms, reluctance to undergo repeated cardioversions, or anxiety about drug side effects.

In the persistent AF group, there was no significant difference in the primary composite end point between the two management strategies. However, the trend was for better outcomes with rate control than rhythm control—just the opposite of the results in the much larger paroxysmal AF group, and in accord with the AFFIRM findings, the cardiologist noted.

Dr. John P. DiMarco commented that, "J-RHYTHM will be very useful to me in my practice."

"The results agreed with my bias that trying to rate-control somebody while they're in AF, when they're in sinus rhythm most of the time, is a very difficult chore," said Dr. DiMarco, professor of medicine and director of the electrophysiology service at the University of Virginia, Charlottesville.

He added that the divergent J-RHYTHM results in patients with paroxysmal as opposed to persistent AF were particularly instructive.

"I think that's something we have to take with us: AF therapy has to be individualized," Dr. DiMarco said. ■