

# 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 Man-

agement 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.

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.

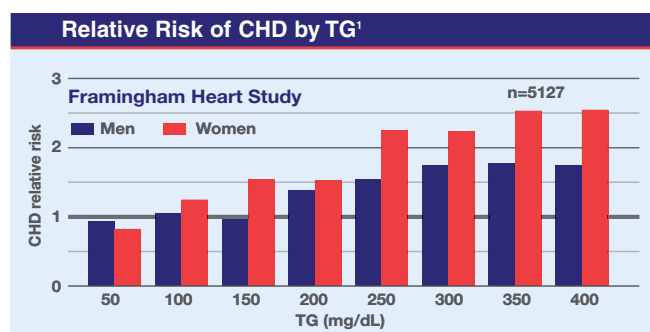
"I think that's something we have to take with us: AF therapy has to be individualized," Dr. DiMarco said.



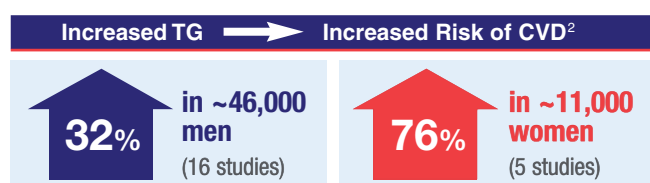
## What TG means to a woman's heart

### Elevated Triglycerides Make a Difference in Women's Risk of CHD

While great attention and clinical efforts have been directed toward LDL-C-lowering, the Framingham Heart Study 30-year follow-up clearly showed that elevated triglycerides (TG) are also associated with an increased relative risk of coronary heart disease (CHD)—especially in women.<sup>1</sup>



In addition, meta-analyses demonstrated that every 1 mmol/L (89 mg/dL) increase in TG increased cardiovascular disease (CVD) risk by:<sup>2</sup>



#### CHD is the #1 Killer of Women

The effect of elevated TG in women is important to keep in mind in view of the fact that CHD is the single leading cause of death among American women, claiming nearly 500,000 lives each year.<sup>3</sup> Menopausal women are particularly at risk, with CHD rates 2 to 3 times those of women the same age who are premenopausal.<sup>3</sup>

#### CHD Risks With Diabetes or Metabolic Syndrome\* in Women: Role of TG and HDL-C

Of the estimated 16 million Americans with diabetes, more than half are women.<sup>4</sup> In women, diabetes is a powerful risk factor for CHD, increasing CHD risk 3-fold to 7-fold compared to a 2-fold to 3-fold increase in men.<sup>5</sup> It has also been shown that metabolic syndrome is associated with a 2-fold risk of CHD mortality in women.<sup>6</sup> **It is important to note that the most common pattern of dyslipidemia in patients with type 2 diabetes is elevated TG levels and decreased HDL-C levels.<sup>7</sup>**

\*At least 3 of the 5 criteria: abdominal obesity with waist circumference >102 cm in men and >88 cm in women; triglycerides ≥150 mg/dL; HDL-C <40 mg/dL in men and <50 mg/dL in women; blood pressure ≥130/85 mmHg; fasting glucose ≥110 mg/dL.<sup>8</sup>

#### More Aggressive Guidelines for TG and HDL-C

While LDL-C lowering is recognized as the primary lipid target to reduce CHD morbidity and mortality, it does not remove all risk.<sup>9</sup> Recent data has shed more light on the role of increased TG and decreased HDL-C in CHD risk. It is critical that these lipid abnormalities be considered and managed, in addition to LDL-C. In fact, the current National Cholesterol Education Program (NCEP) guidelines recommend more aggressive TG and HDL-C target goals.<sup>8</sup> The American Heart Association (AHA) and American Diabetes Association (ADA) recommend similar aggressive goals for TG (<150 mg/dL) and HDL-C (>50 mg/dL) in CVD prevention for women.<sup>10,11</sup>

#### You Can Help Make a Difference

A majority of women are still not aware of the substantial CHD risks posed by abnormal lipid levels.<sup>12</sup> As a physician, you can help make a difference by raising your female patients' awareness of these issues, and by helping them achieve optimal lipid levels, as recommended by the NCEP, the AHA and the ADA.

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