Early Medications Cut Postablation Arrhythmias

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SAN FRANCISCO — Giving antiarrhythmic medications in the first 6 weeks after ablation for atrial fibrillation reduced the rate of clinically significant arrhythmias and the need for cardioversion or hospitalization in a study of 110 patients.

The findings of the Antiarrhythmics After Ablation of Atrial Fibrillation (5A) study provide the first evidence to support the common practice of prescribing antiarrhythmics to reduce arrhythmias that frequently occur after ablation, and were contrary to what the investigators expected, Dr. Jean-Francois Roux said at the annual meeting of the Heart Rhythm Society. Dr. Roux said he has no association with companies that make the medications studied.

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Of the 110 patients in the nonblinded study of patients scheduled to undergo ablation, 53 were randomized to start antiarrhythmia therapy the night of the procedure, using propafenone or flecainide for patients with structural heart disease, or dofetilide or sotalol if they had heart disease. The other 57 patients received only atrioventricular nodal blocking agents after ablation.

Nine patients (17%) in the antiarrhythmics group and 23 (40%) in the control group developed clinically significant atrial arrhythmias or could not tolerate the medications, reported Dr. Roux of the University of Pennsylvania, Philadelphia, and his associates. Significant arrhythmias were defined as atrial fibrillation lasting longer than 24 hours, arrhythmias requiring initiating or changing antiarrhythmic medication, or arrhythmia-related hospitalizations or electrical cardioversions.

Patients were monitored by transtelephonic devices for 4 weeks following ablation and seen 6 weeks after the procedure.

The patients' mean age was 55 years, and 71% were male. Baseline characteristics were similar between groups, with an average left atrial size of 4.2 cm, normal left ventricular ejection fractions, and prior atrial fibrillation lasting an average of 71 months in the medication group and 81 months in the no-medication group. Antiarrhythmic therapy had been used before ablation by 93%-94% of patients. A quarter of each group had undergone previous atrial ablation.

Three of the patients randomized to antiarrhythmics during the study stopped therapy because of side effects including rash, headaches, and severe fatigue.

Using just the "hard" end points of arrhythmias lasting longer than 24 hours or cardioversion or hospitalization for arrhythmia, rates still were significantly lower in the treated group (6 patients, or 11%) compared with the control group (15 patients, or 26%), he said.

Physicians tend to think of ablation and antiarrhythmic drug therapy as separate treatments, but "there can be synergies between the two," Dr. Roux said. Even some patients who hadn't responded to antiarrhythmic therapy before ablation had protective effects against postablation arrhythmias with drug therapy, he said.

A previous study suggested that about 75% of physicians empirically prescribe antiarrhythmic therapy after ablation, and the rest do not.

Before the 5A study, physicians at Dr. Roux's institution were similarly divided in this practice. "After the study, in our group, especially among electrophysiologists, everyone now will put patients on drugs for that 6-week period" after ablation, he said.

Investigators will continue to follow patients for 6 and 12 months to see how the 6-week postablation therapy affects long-term arrhythmia rates.

The study excluded patients who had been treated with amiodarone within 3 months prior to ablation. A separate study is comparing postablation treatment using amiodarone or dronedarone. ■