Imaging-derived Biomarkers Associated with Atrial FIBROsis, Structural Remodeling and the Risk of Cardio-embolic Events in Patients with Atrial Fibrillation – the FIBROS Study

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ABSTRACT

Recent studies demonstrated that despite restoration of the sinus rhythm, patients with a positive history of atrial fibrillation (AF) are still at risk of thromboembolic events. The primary objective of this study is to identify new imaging-derived biomarkers provided by modern imaging technologies, such as cardiac computed tomography angiography, delayed enhancement magnetic resonance imaging, or speckle tracking echocardiography, as well as hematological biomarkers, associated with the risk of intracavitary thrombosis in patients with AF, in order to identify the imaging-derived characteristics associated with an increased risk of cardio-embolic events. Imaging data collected will be post-processed using advanced techniques of computational modeling, in order to fully characterize the degree of structural remodeling and the amount of atrial fibrosis. The primary endpoint of the study is represented by the rate of thromboembolic events. The rate of cardiovascular death, the rate of major adverse cardiovascular events, and the rate of AF recurrence will also be determined in relation to the degree of structural remodeling and atrial fibrosis.

Keywords: atrial fibrillation, atrial fibrosis, inflammation, coagulation, stroke, thrombosis, magnetic resonance, ablation
INTRODUCTION

Atrial fibrillation (AF) is the most common sustained arrhythmia that can appear in patients with or without cardiac comorbidities. The incidence of AF is decreasing; however, its prevalence remained constant, one third of the adult population being affected by this devastating disease. The risk of stroke in patients with AF decreased in the last few years; however, this was not accompanied by a decrease in mortality risk. Recent studies have demonstrated that despite sinus rhythm restoration, patients with a positive history of AF are still at risk of thromboembolic events. Therefore, blood stagnation in the atria is not the only contributor to the development of thromboembolic events.

AF plays an important role in the appearance, maintenance, and recurrence of AF and in the effectiveness of catheter ablation. At the same time, atrial fibrosis is a consequence of AF, showing a vicious circle in which AF begets AF. Atrial fibrosis can be caused by: atrial fibrillation, rapid atrial myocyte depolarization, inflammation, mechanical stretch, atrial distension, cardiac injury, electrical derangements, accumulation of intracellular Ca ions, autocrine and paracrine mediators, oxidative stress, diabetes, obesity, hypercoagulability (activation of PAR1 receptors by thrombin), genetic factors and systemic autoimmune disease. Cardiovascular comorbidities and age (<75 years) did not appear to correlate with the degree of atrial fibrosis.

Inflammation can be a cause or a consequence of AF. A correlation between AF and circulatory levels of inflammatory biomarkers, such as C-reactive protein (CRP), cytokines, interleukin, complement, and activation state of leukocytes has been documented. The link between inflammation and AF includes atrial fibrosis as a main component. Inflammation increases the level of pro-inflammatory cytokines in the blood, such as IL 1, IL 2, IL 6, IL 8, CRP, tumor necrosis factor α, monocyte or chemoattractant protein 1, which stimulate endothelial and other cells. An independent correlation between the level of inflammatory biomarkers and AF was described, the level of CRP and IL 6 correlating with structural remodeling (left atrium enlargement) and with impaired left atrium (LA) function. Furthermore, the level of CRP is an independent predictor of AF, and this level is higher in patients with persistent AF.

Inflammation also has an important role in thrombus formation and ischemic events, this correlation being mediated by endothelial injury, platelet activation, tissue factors, von Willebrand factor, fibrinogen, and P-selectin. Therefore, CRP can become a useful biomarker to assess the risk of thromboembolic events in patients with AF.

Pericardial adipose tissue is a highly metabolically active tissue that can predispose to AF, involving inflammatory cytokines and oxidative stress. Furthermore, it has a quantitative association with the severity of AF. AF produces a hypercoagulable state. Thrombin can initiate a pro-fibrotic, pro-inflammatory, and pro-hypertrophic state via stimulation of protease-activated receptors. New anticoagulant therapy can inhibit PAR1 activation and through it can prevent the development of a substrate for AF.

A CHADS2 and CHA2DS2-VASC score of 0 may be insufficient to avoid thromboembolism events in patients with AF. More information about thromboembolic risk can be obtain by determination of the level of troponin I, CRP, and NT-pro BNP. However, even these hematological biomarkers fail to fully predict the risk of thromboemb-
bolism. Novel studies demonstrated that AF and atrial fibrosis are independent risk factors for stroke, even after the sinus rhythm has been restored. A degree IV (>75%) atrial fibrosis can have a huge impact on the risk of stroke and may be included in the new stroke prediction index.13

**POTENTIAL CONTRIBUTIONS OF THE STUDY**

The phenomenon of atrial fibrosis as a pathogenic mechanism of AF has been described in the literature; however, its role in atrial thrombosis has not been elucidated so far.

The originality of the present study consists in building an algorithm of investigation by which high-quality imaging data will be correlated with hematological markers of inflammation, platelet aggregation, and clotting. A model of complex investigations will be developed to identify patients with increased thromboembolic risk, and thus a large number of cardio-embolic events will be prevented.

**STUDY HYPOTHESIS**

The degree of atrial fibrosis and the level of inflammatory markers in the blood can predict the risk of thromboembolic events in patients with atrial fibrillation.

**STUDY OBJECTIVES**

**Primary objective**

The primary objective of this study is to identify new imaging-derived biomarkers provided by modern imaging technologies such as cardiac computed tomography angiography (CCTA), delayed enhancement MR imaging (DE-MRI), or speckle-tracking echocardiography (STE), as well as hematological biomarkers, associated with the risk of intracavitary thrombosis in patients with AF, in order to identify the characteristics associated with an increased risk of cardio-embolic events.

**Secondary objectives**

This study also aims to evaluate the correlation between the structural remodeling of the left and right atria and the amount of myocardial fibrosis of the left atrium, using DE-MRI. We will determine the function of the left atrium using exercise stress test (EST) and the automated quantification of atrial fibrosis using dedicated software.

At the same time, volumetric assessment of epicardial adipose tissue will be performed in each patient undergoing CCTA and MRI.

We will also look for identification of hematological biomarkers of predisposition for thrombosis and platelet aggregation and evaluate the differences between these biomarkers in blood samples collected from a peripheral line and from the left atrium during interventional ablation procedures. Another important part of this study is to analyze the electrical remodeling of the atrium using a three-dimensional electro-anatomic mapping system and to correlate these findings with the rate of thrombosis and with the level of local hematological markers. We will determine the rate of recurrence of AF, the rate of thromboembolic events, and the rate of major adverse cardiovascular events (MACE), every 3 months during the follow-up.

**METHODS**

**Study design**

This is a prospective, descriptive, cohort study composed of two major parts. In the first part of the study, laboratory tests and necessary interventions will be performed. The second part is represented by the follow-up of patients for 2 years and will contain the analysis of the data obtained during the first part of study. After evaluating eligibility for the screening process, patients who meet the inclusion criteria without exclusion criteria will be included in the study. The study population will be comprised of a minimum of 50 patients. Each patient included in the study will need to be eligible for catheter ablation. Based on the degree of atrial remodeling (size, wall thickness, and function) assessed with CCTA, the study population will be divided in 2 groups. Patients with mild atrial remodeling will be enrolled in the first group, while the second group will contain patients with moderate or severe atrial remodeling.

Personal data of patients will be collected at the start of study. Anamnesis, physical examination, ECG, evaluation of risk factors and comorbidities will be performed in each case. Lab tests will include the level of leukocytes, hs-CRP, and the erythrocyte sedimentation rate. In each case we will exclude the presence of an intracavitary thrombus using transthoracic and transesophageal echocardiography. The structure of atrial anatomy and the level of epicardial adipose tissue will be examined with echocardiography and CCTA. EST will be used for the assessment of cardiac function. Electrophysiological study will be performed in each patient included in the study and the images obtained with CCTA will be merged with the electrical map of the heart.

After trans-septal puncture, but before pulmonary veins isolation, we will harvest blood from the left atrium to determine the level of pro-inflammatory and pro-coagulation
factors. We will quantify the level of hs-CRP, IL-1,6, fibrinogen, tumor necrosis factor, the erythrocyte sedimentation rate, INR, PT, and PT%. At the same time, these factors will be determined from the peripheral blood.

The degree of atrial fibrosis will be assessed using DE-MRI. Upon discharge, we will perform a new ECG to confirm the success of cardioversion. All patients without AF at discharge will be followed-up for 2 years. Patients will be recalled for periodic investigations (anamnesis, physical examination, ECG, echocardiography) in the 3rd, 12th and 24th month and contacted by phone in the 6th and 9th month after cardioversion. At the last session (month 24), MRI and EST will be performed to assess the progression of atrial fibrosis and the changes in atrial function.

INCLUSION AND EXCLUSION CRITERIA

Patients are eligible if they had non-valvular paroxysmal or persistent AF. All patients need to be adults and be able to read and understand the informed consent document. The study cannot be carried out without imaging techniques, therefore patients who present contraindications to imaging tests will be excluded from the study. These conditions are represented by claustrophobia, hypersensitivity to contrast agents (gadolinium, CT contrast agents), pregnancy, acute or chronic kidney failure (stage 3a, 3b, 4, 5), and decompensated cirrhosis. The presence of metallic foreign bodies or cardiac rhythm device are contraindications for magnetic resonance imaging and therefore for the study.

Patients receiving any drug that may affect the level of hematological markers will be excluded from the study. Terminally ill patients and those who may not adhere or may not complete follow-up or do not have reliable information will be also excluded from the study.

ENDPOINTS

The primary endpoint of the study is represented by the rate of thromboembolic events. The rate of cardiovascular death, the rate of MACE, and the rate of AF recurrence will also be determined in relation to the degree of structural remodeling and atrial fibrosis.

DATE STORAGE AND ANALYSES

A dedicated database with the patients’ data and imaging tests will be created and handled with the utmost accuracy and confidentiality, only the staff involved in the research having access to this database. Imaging data stored in the database will undergo complex post-processing in the computational medicine laboratory, using computational simulations and advanced imaging techniques processing. The merging of images obtained with CT scanner with the electro-anatomical map of the left atrium will be performed in real time during the catheter ablation procedure. The quantification of the left atrium fibrosis will be performed by a radiologist.

The statistical analysis will be performed in the medical statistics laboratory of the Center of Advanced Research in Multimodal Cardiac Imaging of SC Cardio Med SRL.

ETHICS

All study procedures are in line with the principles of the Declaration of Helsinki. All patients will sign an informed consent prior to be enrolled in the study. The study received Ethics approval from both institutional boards (approval no 28/28.12.2017 from the Ethics Committee of Cardio Med Medical Center, and approval no. 348/13.12.2017 from the Ethics Committee of the University of Medicine and Pharmacy of Tîrgu Mureș).

CONCLUSION

In AF undergoing complex ablation procedures, the rate of recurrence and the cardioversion succession rate are influenced by several intra- and extra-cardiac factors. Novel studies have shown that in addition to atrial stasis, many factors are involved in the appearance of intra-atrial thrombosis. Patients with positive history of AF have also an increased risk for stroke compared to those who never had atrial fibrillation. It is known that atrial fibrosis, inflammation, and hypercoagulability have an important role in the appearance of intracavitary thrombosis, but the exact mechanisms involved in this correlation have not been elucidated so far. This study will characterize new imaging-derived biomarkers to correlate the structural remodeling and fibrosis of the left and right atrium with the hematological parameters reflecting a high coagulability in the atria, in order identify new tools for predicting the risk of thromboembolic events in patients with AF.

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CONFLICT OF INTEREST

Nothing to declare.

REFERENCES