LETTERS TO THE EDITOR

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'Patient choice' concept in AF ESC Guidelines: is the clinician giving up?

The new AF ESC focused update has very recently introduced the 'patient choice' concept.[1] What it means is that the choice between different therapeutic strategies may be directly made by the patient himself and therefore seems not necessarily related to a specific physician's advice. In our mind, this point could deeply modify current physician role.

New therapies related to technical procedures such as ablations or device implantations have given progressively more space to the creation of cardiological sub-specialists such as 'ablators', 'implanters', 'PCIologues', etc. Those professional figures became very smart in performing their own job but did lose the grip on the other cardiological fields. As a direct consequence the indications of a specific therapy may be exaggerated, thus limiting the patients' rights to be cured at best. For example, the cardiac surgeon may bring a patient to a precocious valvular repair intervention, consulting eventually only the echocardiographist. In a similar manner, the electrophysiologist may directly treat atrial fibrillation patients that ask for ablation and the haemodynamist may perform PCI even in asymptomatic patients with non-significant coronary stenosis who are seeking to reach the perfect coronary width.

The role of the clinician, who knows the patients' characteristics and has a 360° knowledge of pathologies, guidelines and therapeutic implications, is thus progressively disappearing. He is actually taking care of the patients but hardly interferes with the technical indications to therapy nowadays. He is busier and busier in management activities and drowned by bureaucracy, with a progressive loss of knowledge, experience, and clinical feeling that should be the basis and constitute the deepest sense of the medical profession. Who can advice the patient to his best if not the one who knows his pathologies, his history, and all the clinical aspects of the body and mind of that specific individual? The 'medical technician', who could also retain some possible conflicts of interest?

What does 'patient choice' mean then? Could the patient be informed by other sources such as blogs, social networks, good friends, and next-door guys? Moreover, since we are speaking of European guidelines, are all European countries able to absorb that 'choice' in the same way? Will different cultural levels and health systems organizations translate this new concept in the same way with a proper patient decision making?

We are deeply worried that 'patient choice' would mean to pass from an era when the patient was fully clinically evaluated as an individual and his pathology interpreted in his own context to a techno-medical era where every single pathology is met by a specific advanced technique capable of great benefits but often lacking influence on prognosis and burdened by major complications.

Saying 'patient choice' means implying the definition of an advisory figure and we have the feeling that the best advisor should be a fully competent one, for whom the patient's health is of primary importance, who deeply knows physical and emotional reactions of the patient and without any possible conflict of interest. Is there anyone like this anymore? We think the answer is the Clinical Cardiologist. This is a figure we always needed and that has to be resuscitated and revalued for patient's sake.

Reference

1. Camm AJ, Lip GYH, De Caterina R, Savelieva I, Atar D, Hohnloser SH *et al.* 2012 focused update of the ESC Guidelines for the management of atrial fibrillation. *Europace* 2012;**14**:1385–413.

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'Patient choice' concept in AF ESC Guidelines: is the clinician giving up? Reply

Dear Sir,

I was very surprised when Professor Capucci and others first raised this matter at the ESC Annual Congress where the AF Guideline Focused Update was first presented. To most physicians it is now routine to engage their patients in a discussion of the advantages and disadvantages of various treatment options. When the physician's judgement is that a particular course of action is preferable to another, he should advise the patient accordingly. In some instances there is equipoise—it is not clear what the best course of action might be, and in such circumstances it is the responsibility of the physician to explain this dilemma to the patient and invite the patient to contribute to the decision. Many patients simply want to follow the doctor's advice, and when this is the case the doctor may try to put himself in the place of the patients and guide his or her decision.

In other circumstances the selection of a treatment might involve choosing between an invasive versus a non-invasive approach, the need for an anaesthetic or not, one set of risks or another. These choices are not only for the doctor—the patient should be consulted and his preferences are relevant.

Inserting a choice box in a flow chart[1] is not an abrogation of medical responsibility; it is an acknowledgement of genuine equipoise, or other circumstances where patient choice is highly relevant. It is hoped that the patient will not consult just the Internet or strangers, but they may wish to discuss the choice they are given with their family, their friends or their general practitioner, rather than leave the decision simply in the hands the specialist who is dealing with only one specific issue, such as left atrial ablation. When the care pathway is clear and unambiguous, there may be little choice for the patient other than accepting or declining the advice that has been given. However, even when there is an important decision to be

made, it would be wrong to place too much responsibly on the patient, but guidance rather than instruction from the doctor would then be most appropriate.

Reference

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Questionable levels of evidence in new atrial fibrillation guidelines?

We read with interest the 2012 focused update of the ESC Guidelines for the management of atrial fibrillation (AF), and more specifically the recommendations formulated for catheter ablation (CA).[1]

A class I-level of evidence (LoE) A recommendation is attributed to CA for paroxysmal AF in symptomatic drug-refractory patients. In randomized controlled trials (RCTs), AF recurs off-antiarrhythmic drug (AAD) in one-third of patients, 1 year after a single CA.[2,3] We have documented that AF recurs in up to 50% after 2 years, which is in line with other observational studies.[4,5] The procedure has a mortality risk of up to 1.5 per thousand,[6] and life-threatening complications such as cardiac tamponade or stroke occur in 1–3% of cases.[7] Long-term effects beyond 5 years remain unknown. Based on real-world Belgian data, we calculated that one CA–AF on average costs €9600.[5] The overall effect of CA–AF is disappointing considering the fact that the primary aim of CA ideally should be to cure AF.[8,9]

The 2012 guideline upgrades the abovementioned recommendation from class IIa-LoE A to class I-LoE A in patients who prefer rhythm control. This is not supported by new RCT evidence. Moreover, how might patients be able to express such preference? Rhythm control with AADs has not been documented to be superior over rate control.[10,11] Furthermore, no single trial has compared CA with rate control in paroxysmal AF.

A class IIA-LoE B recommendation is given to CA as a first-line therapy in selected patients. Two recent RCTs have tested this strategy in paroxysmal AF. In the MANTRA-PAF trial, the cumulative AF burden over 2 years was not significantly different among patients treated with drugs vs. those treated with CA. There was no difference in AF burden between the two study groups at 3, 6, 12, and 18 months. At 2 years, the difference was significant in favour of CA. Symptomatic AF occurred in 6.8% of CA patients vs. in 16.2% in drug-treated patients. In this healthy population, there were three deaths in the ablation group and four deaths in the drug group.[12]

In the RAAFT-2 trial, patients who underwent CA had a significantly lower risk of a first recurrence of atrial tachyarrhythmia over 21 months (55 vs. 72%). However, there was no significant difference in symptomatic events between the two groups (24% with CA vs. 31% with AADs).[13]

For CA as first-line treatment, the new guideline upgrades its recommendation from class IIb-LoE B to class IIa-LoE B. In contrast, RCTs indicate that the symptomatic benefit of CA as a first-line treatment is hardly better than an initial treatment with an AAD.

Labelling the abovementioned recommendations with an LoE A/B is misleading since they are not supported by solid evidence. CA–AF is an invasive procedure that is expensive and performs relatively poorly with an unknown long-term effect. Its use should be strictly limited to well-informed and highly symptomatic drug-refractory patients.

Conflict of interest: none declared.

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Questionable levels of evidence in new atrial fibrillation guidelines? Reply

We agree with van Brabandt and his coauthors that catheter ablation of atrial fibrillation (AF) does not completely cure AF, and that it does not come without complications. We do not share their overly pessimistic view on catheter ablation of AF: several controlled randomized trials demonstrate that while AF ablation does not 'cure' AF, which would not be expected in light of the multiple causes of AF,[1] the recurrence rate after AF ablation is lower compared with antiarrhythmic drug therapy (70 vs. 50%[2,3]). MANTRA-