

# WHY TREAT AFIB SURGICALLY?

ACT  
against Afib

# WHY *TREAT* AFIB SURGICALLY?

Even as the medical risks of atrial fibrillation (Afib) become more widely known and treatments are proven effective ...

only about

**1/3**

of Afib is treated  
during heart surgery.<sup>1,2</sup>

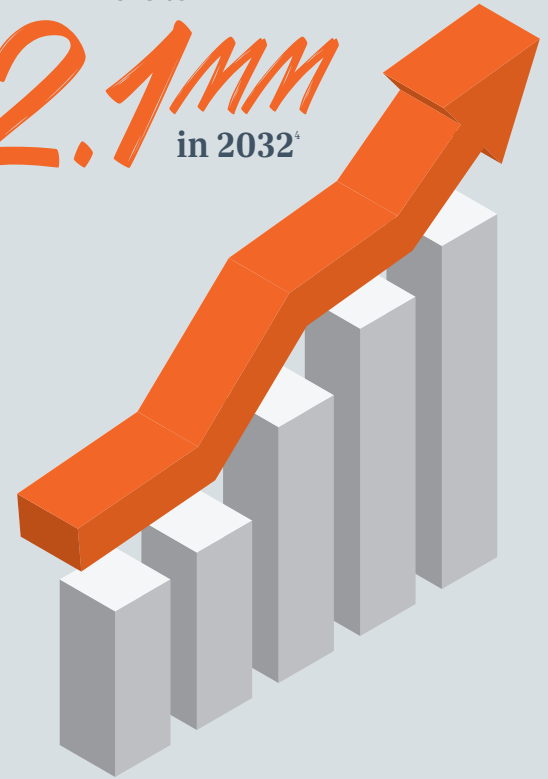
more than

**33**  
**MILLION**

people currently suffer  
from Afib worldwide.<sup>3</sup>

In the U.S. alone, the prevalence  
of Afib is projected to increase  
from 5.2MM in 2010 to

**12.1MM**  
in 2032<sup>4</sup>



# Afib is a Real Burden



## Clinical Burden

Patients with Afib have:

**5x** increase in stroke risk<sup>4</sup>

**5x** increase in heart failure (HF) development<sup>5</sup>

**46%** greater risk of death<sup>5,7</sup>

More cardiac complications<sup>6</sup>

## Patient Burden

Patients with Afib have:

- **Decrease** in general and mental health<sup>8</sup>
- **Decreased** cognitive function<sup>9,10,11</sup>
- Approximately 10 outpatient **hospital visits** and > 50 **physician encounters** per year on average<sup>12</sup>
- Heightened **anxiety** about medications<sup>13</sup>
- **Burnout** from frequent follow-up appointments<sup>14</sup>
- Up to a 47% **reduction** in quality of life<sup>15-19</sup>

## Economic Burden



Afib patients cost **\$8,700** more per year to treat<sup>20</sup>



**564,000** ED visits per year<sup>21</sup>



**470,000**, or **~65%** of Afib patients presenting to the ED, are admitted each year<sup>22</sup>

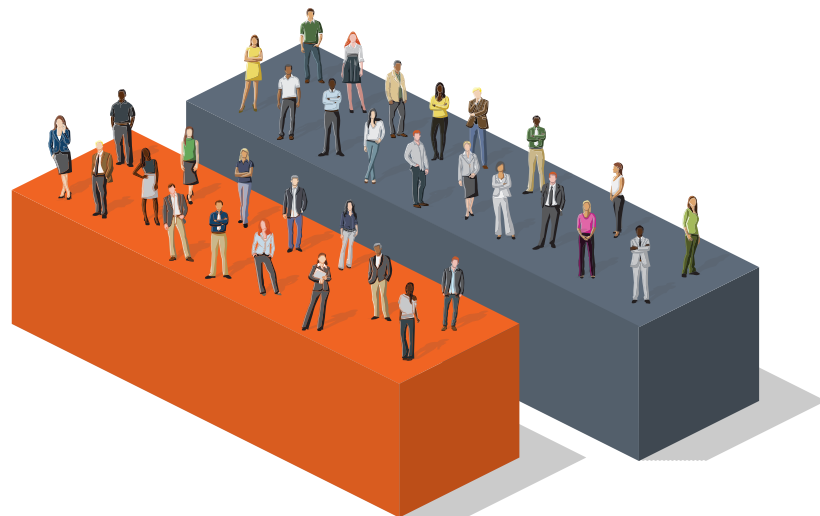


Afib costs the U.S. health system **\$26 billion** per year<sup>23</sup>

# Afib Burden is Real

**Patients Understand Cancer is Serious. So is the Burden of Afib.**

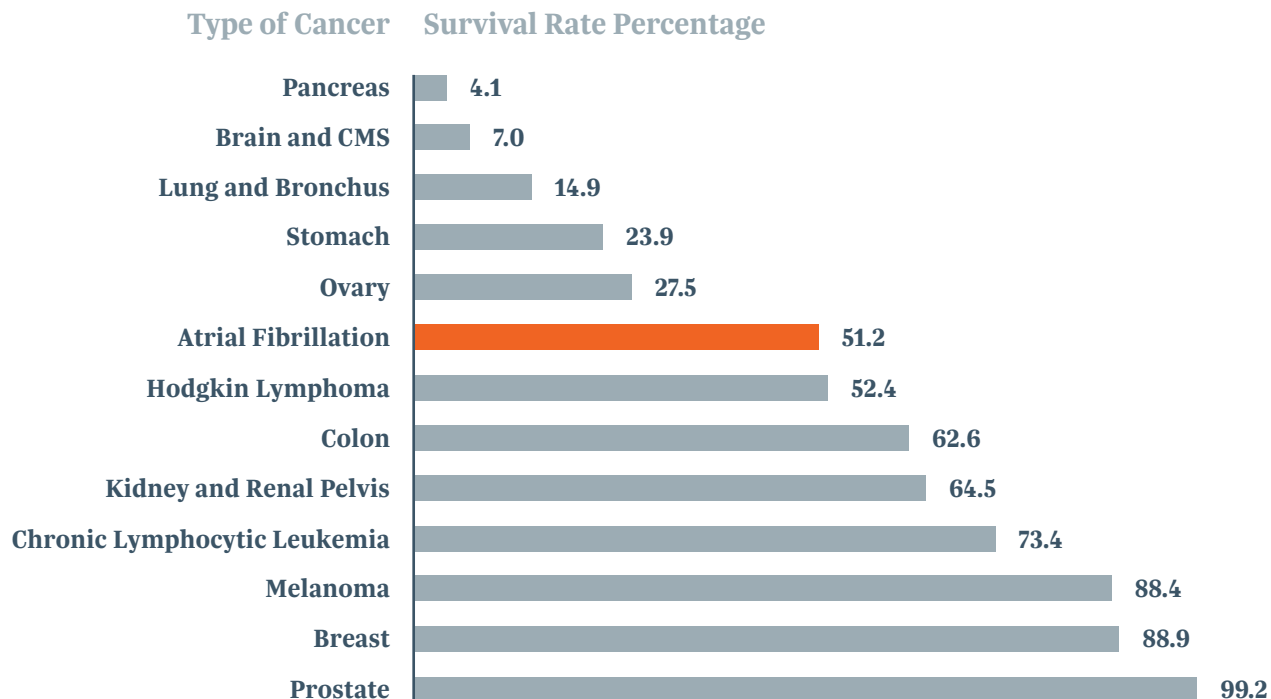
Although patients with Afib have a 5-year lower survival rate than patients with many types of cancer, the Afib often goes untreated during heart surgeries — especially for AVR and CABG patients.



AVR: aortic valve repair/replacement

CABG: coronary artery bypass graft

# “Most Feared” Cancer Survival Rates



Sources:

\*Adapted from: Piccini, J.P. et al. (2014). Clinical course of atrial fibrillation in older adults: the importance of cardiovascular events beyond stroke. Eur Heart J, 35(4):250-6.

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# Help Patients Live Better. Longer.

**Increasingly more data show that surgical ablation during heart surgery reduces mortality, risk of stroke, and other post-surgical complications. Concomitant surgical ablation to treat Afib isn't as risky as you might think.**

Patients who undergo concomitant treatment may actually have reduced hospital LOS.<sup>24</sup> One year after CABG surgery with surgical ablation for Afib, survival improves by 42%.<sup>25</sup> Ten years after CABG surgery, Afib patients who receive concomitant treatment show a 20% improvement in life expectancy.<sup>26</sup> What's more, concomitant surgical ablation gives patients with non-paroxysmal Afib the highest chance at restoring NSR.<sup>27-31</sup> Patients with a surgically restored NSR show improvement in quality of life.<sup>8</sup>



# 42% Higher Survival at 1 Year

European Journal of Cardio-Thoracic Surgery 9(2017) 1-8  
doi:10.1093/ejcts/evx136

ORIGINAL ARTICLE

See this article as Rankin JS, Lemeche M, Mayo J, Brink-Fores M, Ferguson M, Balfour V. One-year mortality and costs associated with surgical ablation for atrial fibrillation concomitant to coronary artery bypass grafting. *Eur J Cardiothorac Surg*. 2017; doi:10.1093/ejcts/evx136.

## One-year mortality and costs associated with surgical ablation for atrial fibrillation concomitant to coronary artery bypass grafting†

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Received 13 October 2017; revised in final form 3 February 2017; accepted 28 February 2017

### Abstract

**OBJECTIVE:** While surgical ablation (SA) for persistent atrial fibrillation (AF) can reduce recurrence of AF, its impact on long-term survival and health care costs remains controversial. This study defines the clinical outcomes and costs associated with SA in patients with prior AF undergoing coronary artery bypass grafting (CABG).

**METHODS:** A total of 3765 Medicare beneficiaries with prior AF who underwent CABG in 2013 were divided into 2 groups: those with and those without concomitant SA. Risk-adjusted early (0–90 days) and late (91–364 days) postoperative outcomes and apparent costs were compared.

**RESULTS:** SA was performed in 17% of CABG patients with prior AF. Preoperative characteristics favoured patients with SA: emergent presentation (19% vs 27%), heart failure in the 30 days prior to CABG (31% vs 38%), chronic lung disease (27% vs 31%) and renal failure (6% vs 7%) ( $P < 0.05$ ). Risk-adjusted operative mortality and postoperative stroke rates were similar in the 2 groups. Risk-adjusted hospital stay similar through 90 days, but significantly better with SA after 90 days (hazard ratio (HR) = 0.58,  $P = 0.03$ ). At 1 year, the risk-adjusted incidence of cardiovascular implantable electronic device implantation was greater with SA (HR = 1.25,  $P = 0.01$ ). Risk-adjusted costs for the CABG admission (HR = 1.11,  $P = 0.07$ ) and repeat care through 1 year (HR = 1.06,  $P = 0.05$ ) were also greater with SA.

**CONCLUSIONS:** In the US Medicare population, SA was performed in 17% of CABG-AF patients in 2013. Operative risks for mortality and stroke did not increase with SA, but costs did. Patients receiving SA, however, had significantly better risk-adjusted late survival.

**Keywords:** Atrial ablation • Atrial fibrillation • Coronary artery bypass grafting • Mortality • Medicine

### INTRODUCTION

Surgical ablation (SA) for atrial fibrillation (AF) has been shown to reduce AF recurrence in randomized controlled trials [1–6] and systematic reviews [4–6]. Most SAs are performed concomitantly with other cardiac procedures. While the impact of SA on long-term survival and health care costs remains controversial, this study defines the clinical outcomes and costs associated with SA in patients with prior AF undergoing coronary artery bypass grafting (CABG).

### METHODS

**Database and study population.** A total of 3765 Medicare beneficiaries with prior AF who underwent CABG in 2013 were divided into 2 groups: those with and those without concomitant SA. Risk-adjusted early (0–90 days) and late (91–364 days) postoperative outcomes and apparent costs were compared.

“One-year mortality and costs associated with surgical ablation for atrial fibrillation concomitant to coronary artery bypass grafting”

N = 3,745  
Risk-Adjusted Patients

# 31% Higher Survival at 5 Years

## J. Maxwell Chamberlain Memorial Paper for Adult Cardiac Surgery Does Surgical Atrial Fibrillation Ablation Improve Long-Term Survival? A Multicenter Analysis

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<sup>h</sup>Commercial Relationships: A. M. Gillinos: Ownership Interest, Clear Catheter Systems; Research Grant, Abbott; Consultant/Advisory Board, Abbott, AmCare, Clear Catheter Systems, CryoLife, Edwards Lifesciences, Medtronic; Speakers Bureau/Honoraria, AmCare

**Purpose:** STS recently issued new guidelines on surgical atrial fibrillation ablation (SAFA), given the effectiveness of this technique in achieving freedom from atrial fibrillation (AF). The goal of this analysis was to assess the influence of SAFA on long-term survival.

**Methods:** A multicenter, retrospective analysis of 20,407 consecutive coronary artery bypass grafting (CABG) or valve procedures from 2008 to 2015 in seven medical centers reporting to a prospectively maintained clinical registry was conducted. Patients undergoing first-time surgery with documented preoperative AF were included in the final analysis ( $n=2795$ ). Patients with preoperative AF undergoing CABG or valve surgery with concomitant SAFA were then compared to those undergoing surgery without SAFA. The primary endpoint was all-cause mortality. Secondary endpoints included in-hospital morbidity and mortality. A propensity model and inverse probability weighting were used to estimate adjusted short- and long-term outcomes for the two groups.

**Results:** The overall frequency of SAFA in the study cohort was 28.3% ( $n=790$ ), and there was no difference in preoperative AF volume or timing between the two groups ( $P = 0.001$ ).

“Does Surgical Atrial Fibrillation Ablation Improve Long-Term Survival? A Multicenter Analysis”

N = 20,407  
Risk-Adjusted Patients

# 20% Higher Survival at 10 Years

ACQUIRED: ARRHYTHMIA

## Performance of the Cox-maze IV procedure is associated with improved long-term survival in patients with atrial fibrillation undergoing cardiac surgery

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### ABSTRACT

**Objective:** Atrial fibrillation (AF) is associated with an increased mortality risk. The Cox-maze IV procedure (CM4) performed concomitantly with other cardiac procedures has been shown to be effective for resetting sinus rhythm. However, few data have been published on the late survival of patients undergoing a concomitant CM4.

**Methods:** Patients undergoing cardiac surgery were retrospectively reviewed from 2001 to 2016 ( $n = 10,859$ ). Patients were stratified into 3 groups: patients with a history of AF receiving a concomitant CM4 (CM4;  $n = 438$ ), patients with a history of AF unaddressed during surgery (Unaddressed AF;  $n = 1510$ ), and patients without AF history (No AF;  $n = 8911$ ). Propensity score matching was conducted between the CM4 and Unaddressed AF groups, and between the CM4 and No AF groups.

**Results:** Thirty-day mortality was similar between the matched groups. Kaplan-Meier analysis showed greater survival for CM4 compared to Unaddressed AF ( $P = .004$ ). Ten-year survival was 62% for CM4 and 42% for Unaddressed AF. Adjusted hazard ratio was 0.47 (95% confidence interval, 0.26–0.86,  $P = 0.04$ ). No difference in survival was found between CM4 and No AF groups with the Kaplan-Meier analysis ( $P = .807$ ). Ten-year survival was 63% for CM4 and 55% for No AF. Adjusted hazard ratio was 1.03 (95% confidence interval, 0.51–2.11,  $P = .929$ ).

**Conclusions:** For selected patients with a history of AF undergoing cardiac surgery, concomitant CM4 did not add significantly to postoperative morbidity or mortality and was associated with improved late survival compared with patients with unaddressed AF and a similar survival to patients without a history of AF. (J Thorac Cardiovasc Surg 2018;155:159–70)

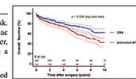


Figure 1. Survival of concomitant Cox-maze versus no ablation for atrial fibrillation during surgery.

**Conflict of Interest Statement:** In patients with a history of atrial fibrillation undergoing cardiac surgery, a concomitant Cox-maze IV procedure was associated with improved long-term survival.

**Keywords:** The effectiveness of surgical ablation for the treatment of atrial fibrillation has been well established. However, even patients with atrial fibrillation undergoing heart surgery do not receive concomitant ablation. Our findings show that the addition of a Cox-maze IV procedure does not add significantly to postoperative morbidity or mortality and is associated with improved long-term survival.

See Editorial Commentary page 171.

See Editorial page 157.

“Performance of the Cox-maze IV procedure is associated with improved long-term survival in patients with atrial fibrillation undergoing cardiac surgery”

N = 10,859  
Risk-Adjusted Patients

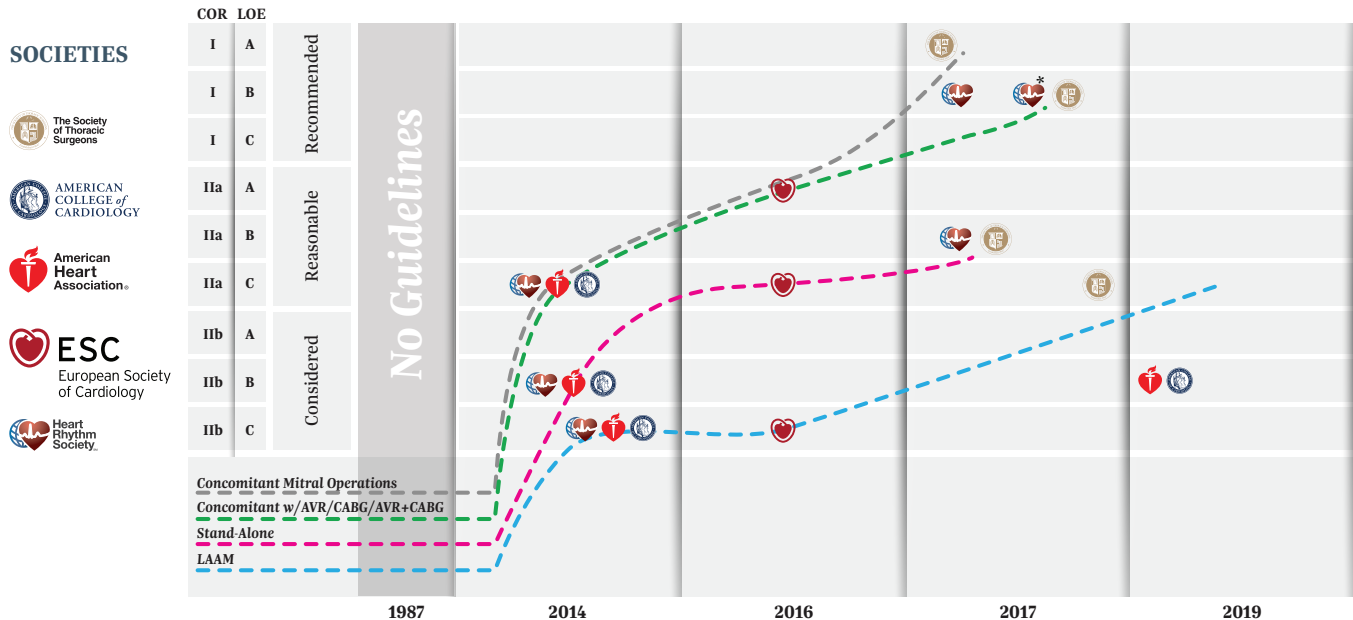
LOS: length of stay

NSR: normal sinus rhythm

CABG: coronary artery bypass graft

# Do Something

Concomitant Surgical Ablation has a **Class I** Recommendation



A wealth of data led the Surgical Thoracic and Heart Rhythm Societies to make a Class I recommendation that patients with Afib undergoing valve or coronary surgeries receive surgical Afib treatment.<sup>32-37</sup>

\*AVR/CABG concomitant ablation Class I LDR for symptomatic persistent and long-standing persistent \*refractory or intolerant to at least one Class I or III antiarrhythmic medication.\*

# Cox Maze IV yields the highest efficacy for Afib treatment, but literature shows progressive efficacy for each additive lesion set of the Cox Maze IV.

**Lesion Set Options**      Reported Experiences: 1–5 year retro and prospective peer-reviewed publications both on and off AADs

Approach	Reported Experiences w/ Surgical Ablation	Ablation Duration	PVI Catheter Outcomes w/ Lone Afib	
1. Pulmonary Vein Isolation (PVI)	PAF ~ <b>50–90%</b> <sup>33,42,47</sup>	Note: + = Time  +	PAF ~ <b>47–80%</b> 47% – 1 ablation <sup>38</sup>	nPAF ~ <b>25–52%</b> 25% – 1 ablation <sup>41</sup>
	nPAF ~ <b>60%</b> <sup>33,43</sup>		74% – 2 ablations <sup>38</sup> 80% – 3 ablations <sup>38</sup> ~70% – meta-analysis <sup>39</sup>	43% – multiple ablations <sup>40</sup> 52% – multiple ablations <sup>41</sup> ~50% – meta-analysis <sup>39</sup>
2. Box Set Lesion (Box)	nPAF ~ <b>55–70%</b> <sup>43,48</sup>	++		
3. Left Atrial Lesion Set (LAL)	nPAF ~ <b>73–86%</b> <sup>45,49</sup> ~20% fewer atrial flutter <sup>46</sup>	+++		
4. Bi-Atrial Lesion Set (Maze)	nPAF ~ <b>80–90%</b> <sup>27,31</sup>	++++		

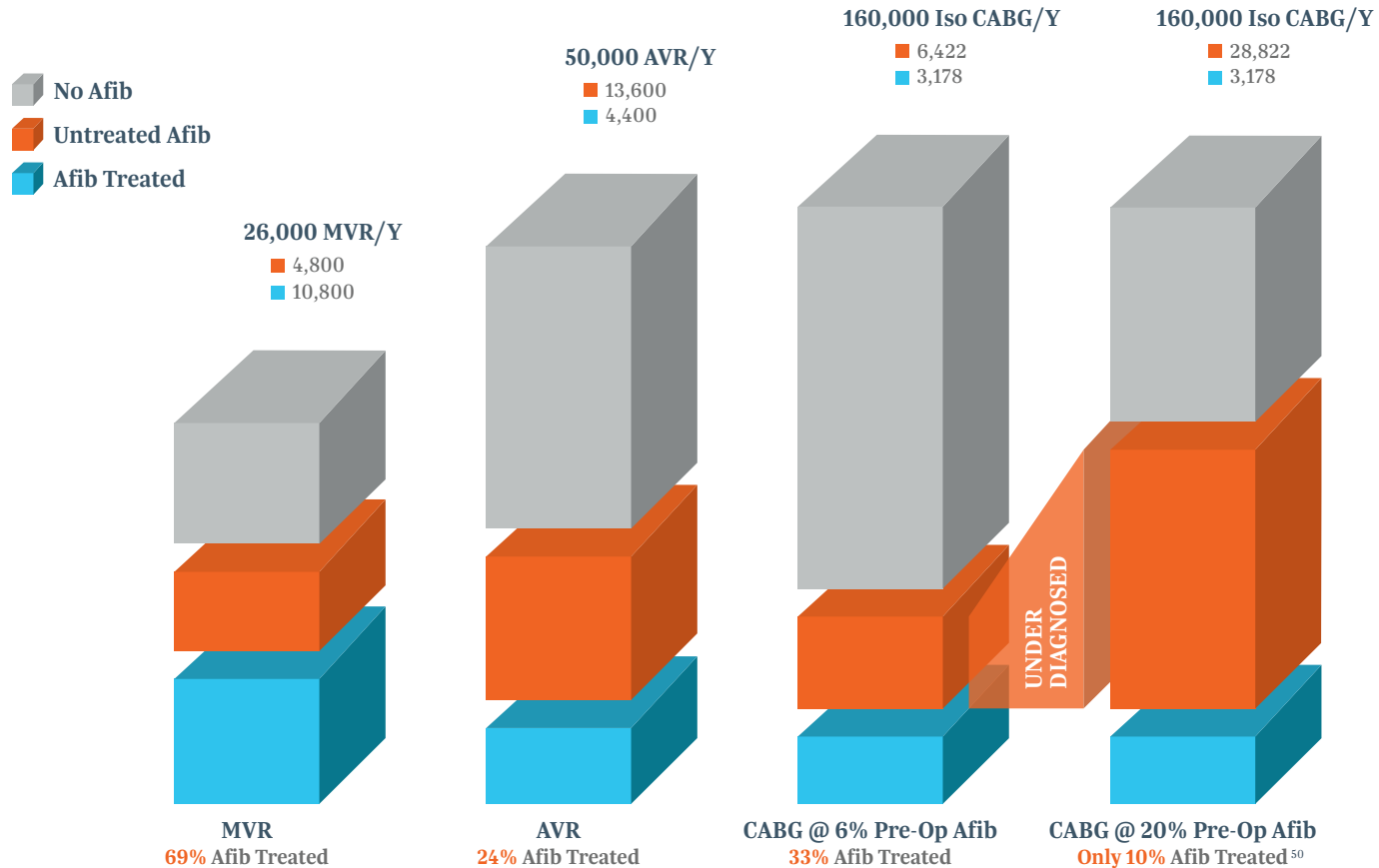
The success of various procedures may be influenced by several factors, which may predict the outcome, such as duration of pre-procedural Afib, type of Afib, lesion set performed, left atrial size, patient’s age, atrial fibrillation wave <1.0mm, experience of the operator, left atrial reduction, and device used.

# Afib is Surgically Under-Treated and Under-Diagnosed.

Of patients that the consulting Interventional Cardiologist (IC) refers for CABG, **less than 10% with Afib get concomitant surgical ablation (SA)**<sup>50</sup> to restore NSR that could help them live longer and better.



# Afib Incidence and Surgical Ablation Treatment Rates in Cardiac Surgery<sup>1</sup>



# Be Part of the Heart Failure Solution

*"HF BEGETS AF,  
AF BEGETS HF"*<sup>52</sup>

Recent research also points to a **relationship between Afib and heart failure**, in which Afib may be both a causal factor and a consequence of HF.<sup>52,53</sup> Studies show that the prevalence of Afib increases with the severity of heart failure,<sup>54</sup> and the development of Afib in HF patients is one of the leading causes of clinical deterioration.<sup>55</sup>

**Restoration of NSR improved ejection fraction 8%–18%**<sup>56,57</sup>

**Restoration of NSR resulted in decreased mortality, improvement of LVEF, reduced left atrium dimensions, and might improve NYHA HF Class.**<sup>56,57</sup>

# Screen for Afib in CABG Patients

In a population of more than 79,000 patients, 20% of CABG patients had an admission for Afib within 3 years before the CABG, but the Afib diagnosis was often unknown during referral.<sup>50</sup>

Collaborate with the primary physician to discuss SA as part of the surgical plan.

## **Identify Patients with Afib:**

- Include screening questions at referral in the surgical intake process, such as:
  - *Have you ever been told you have an irregular heart beat?*
  - *Have you ever had heart palpitations?*
  - *Have you ever taken blood thinners?*
  - *Have you ever taken medicines to manage your heart rate?*
- Review chart history for a past Afib diagnosis, Holter monitoring, cardioversion, or catheter ablation.



## Did you Know?

Patients who are managed by a Nurse Navigator have:<sup>58</sup>

- Higher satisfaction
- Fewer readmissions and ED visits
- Improved outcomes
- Higher retention in the same system for other care needs
- Reduced length of stay in the ICU

- Contact primary physician, such as the General Cardiologist or Heart Failure Specialist, to ask about any history of Afib.
- Implement screening and a follow-up process for patients who present to the ED with Afib.
- Discuss concomitant surgical Afib treatment during the referral process.
- Consider active navigation of Afib patients with a Nurse Navigator to guide the patient through the referral, treatment, and follow-up management.



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*Individual results may vary. Please consult with your physician regarding your condition and appropriate medical treatment.*

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PM-US-0411A-0221-G

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