Predictors of atrial fibrillation after off-pump coronary artery bypass graft surgery

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Background. Postoperative atrial fibrillation (AF) is one of the most common complications after cardiothoracic surgery and is associated with an increased risk of stroke, and longer hospital stay. The pathophysiology of postoperative AF is uncertain, and its prevention remains unsatisfactory. Many previous studies have examined the predictors of AF after on-pump coronary artery bypass graft surgery (CABG), but there are few reports after off-pump CABG.

Methods. The aim of the present prospective observational study, in which 296 consecutive patients were enrolled, was to elucidate the predictors of AF after off-pump CABG. The association of perioperative factors with AF was investigated using univariate analysis. Significant variables were included into a stepwise logistic regression model to ascertain their independent influence on the occurrence of AF.

Results. The incidence of AF was 32%. AF prolonged the time until patients were fit for discharge by 3 days ($P < 0.01$). Stepwise multivariate analysis identified increasing age [odds ratio (OR) 1.44 per 10-yr increase; 95% confidence interval (CI) 1.06–1.95], intraoperative average core temperature (OR 1.64; 95% CI 1.05–2.56), the average cardiac index in the intensive care unit (OR 0.37; 95% CI 0.19–0.71), and intraoperative fluid balance (OR 0.96 per 100-ml increase; 95% CI 0.93–0.99) as independent predictors of postoperative AF.

Conclusion. Our present findings indicate that ageing, the intraoperative fluid balance, and postoperative cardiac index are associated with the onset of AF after off-pump CABG.


Keywords: anaesthesia, cardiovascular; atrial fibrillation, arrhythmia; complications, perioperative; surgery, cardiovascular

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patients with a history of β-blocker use, but whether prophylactic β-blocker administration reduces the length of hospitalization remains to be seen.7 Identifying the population most at risk of postoperative AF could lead to more targeted preventive or therapeutic interventions, while further reducing the potential for antiarrhythmic-related toxicity and drug costs.

Many previous studies have investigated the predictors of AF after conventional on-pump CABG, but there have been few papers examining AF after off-pump cardiac surgery.8 The goal of the present study was to identify perioperative predictors of AF after off-pump CABG.

Methods
A total of 296 consecutive patients who underwent off-pump CABG surgery between January 1, 2001 and December 31, 2004 in our institution were enrolled in this prospective observational study. The mean age of the study population was 69 yr (range 38–87 yr). Two hundred and twenty-four of the patients were male. The study was approved by the Review Board on Human Experiments at the Kyoto Prefectural University of Medicine. Written informed consent was obtained from all patients. Patients who had had previous cardiac surgery were excluded, as were patients having concomitant major surgery. All patients were in sinus rhythm at the outset of the study, including patients with a history of paroxysmal AF.

All preoperative medications except β-blockers, diuretics, angiotensin-converting enzyme inhibitors, and calcium channel blockers were routinely omitted on the day of surgery. Our routine AF prophylaxis strategy consisted of potassium and magnesium supplementation in the operating room and in the intensive care unit (ICU). No other drugs were continued routinely, and no other drugs were given for arrhythmia prophylaxis. Preoperative β-blockers were continued after operation to avoid withdrawal.

All surgical procedures were performed by the same surgical team. Anticoagulation was provided by i.v. heparin (1 mg kg\(^{-1}\)) which was given after graft harvesting. A mechanical stabilizer (Octopus, Medtronic Inc., Minneapolis, MN, USA) and a heart positioner (Starfish or Urchin, Medtronic Inc.) were used to control motion of the beating heart.

Intraoperative haemodynamic management was standardized. Hypotension (systolic blood pressure <90 mm Hg) was treated with volume replacement, ephedrine (0.05 mg kg\(^{-1}\)), or methoxamine (0.02 mg kg\(^{-1}\)) as indicated. Persistent hypertension (systolic blood pressure >140 mm Hg) was treated by increasing the depth of anaesthesia or by administration of nitroglycerin (initially 0.8 μg kg\(^{-1}\) min\(^{-1}\)). Tachycardia (heart rate >100 beats min\(^{-1}\)) was also treated by increasing the depth of anaesthesia or by using an ultra-short-acting β-blocker (landelol hydrochloride, 0.02 mg kg\(^{-1}\) min\(^{-1}\)) and edrophonium chloride (0.05 mg kg\(^{-1}\)). Bradycardia (heart rate <50 beats min\(^{-1}\)) was treated with pericardial ventricular pacing.

Intraoperatively, both groups were given 12 ml kg\(^{-1}\) h\(^{-1}\) of lactated Ringer’s solution, and i.v. crystalloid fluids were not warmed. When blood loss exceeded 30% of the blood volume, albumin was administered. When patients’ haematocrit decreased to less than 25%, red blood cells were transfused. The ambient operating room temperature was maintained at approximately 23°C. Patients were extubated in the operating room or ICU. The extubation criteria were as follows: patient responsive to simple commands; body core temperature >35.0°C; haemodynamically stable; absence of uncontrolled arrhythmia; chest tube drainage <1 ml kg\(^{-1}\) over 30 min; and blood gas analysis (pH >7.30, arterial oxygen tension >8 kPa, P\(_{CO2}\) <7.3 kPa) at an inspired oxygen fraction <0.4. The discharge criteria from ICU were as follows: alert and cooperative; no inotropic support; no significant arrhythmia; adequate ventilation; chest tube drainage <1 ml kg\(^{-1}\) over 120 min; urine output >0.5 ml kg\(^{-1}\) h\(^{-1}\); no recent generalized seizures; and no active seizures.

The length of hospitalization for this procedure is generally longer in Japan than in the Europe or USA as the Japanese health-care system does not demand a short hospital stay, and allows patients to stay until a nursing home bed becomes available. Thus, we determined when patients met the discharge criteria rather than relying on the actual duration of hospitalization. The discharge criteria from the hospital were as follows: haemodynamically stable; stable cardiac rhythm; no infected incisions and afebrile; ability to void and have bowel movements; independent ambulation and feeding; and ability to walk upstairs. The physicians blinded to the predictive criteria being studied made all the clinical decisions.

Continuous ECG monitoring was performed for at least 72 h after surgery depending on the patient’s condition. Twelve-lead ECGs were recorded if arrhythmia was suspected. After discharge from the hospital, intermittent ECG assessments (once per week) were performed until 1 month after surgery. Each episode of arrhythmias was recorded and interpreted by an independent physician. AF, atrial flutter, and atrial tachycardia were defined according to previous studies.9 AF was defined as non-sustained if lasting between 10 beats and 10 min and sustained if persisting for more than 10 min.

The following data were prospectively collected, preoperative variables included age, gender, body mass index, medications, left ventricular fractional shortening, PR interval, and P-wave duration of ECG, history of paroxysmal AF, hypertension, diabetes mellitus, chronic obstructive pulmonary disease under medical treatment, neurological events (e.g. stroke, transient ischaemic attack, epilepsy), hepatic insufficiency (alanine amino transferase or aspartate aminotransferase >50 IU litre\(^{-1}\), or ICG retention rate at 15 min >20%), and renal insufficiency (creatinine >132.6 μmol litre\(^{-1}\)). Perioperative data included perioperative core temperature (in the operating room: average of readings taken every 30 min, and in the
ICU for the first 12 h: average of readings taken every 1 h), intraoperative total amounts of noradrenaline, dopamine, dobutamine, blood lactate concentration at the end of surgery, the base excess at the end of surgery, perioperative fluid balance (in the operating room, and in the ICU for the first 12 h), perioperative total blood loss (the sum of blood loss in the operating room and in ICU for the first 12 h), perioperative average cardiac index (in the operating room: average of readings taken every 30 min, and in the ICU for the first 12 h: average of readings taken every 1 h), intraoperative average central venous pressure (average of readings taken every 30 min), number of distal anastomoses, and postoperative pleural effusion.

Statistics
Atrial flutter, atrial tachycardia, and other arrhythmias were not included in the same group as AF because their mechanisms differ. Only sustained episodes of AF were considered. Univariate characteristics between patients with and without AF were compared using a Mann–Whitney U-test for continuous variables and χ² tests with a Yates correction for categorical variables.

A model was built using stepwise logistic regression to identify the subset of variables that jointly predicted post-CABG AF risk. All variables whose univariate tests resulted in a P-value of <0.2 were considered in the multivariate analysis. A backward stepwise logistic regression analysis was used to identify the subset of variables that predicted postoperative AF. The area under the receiver operating characteristic curve was computed for use as a descriptive tool for measuring the bias of the model. A Hosmer–Lemeshow goodness-of-fit statistic was computed to examine the calibration of the model.

Results
Thirty-six patients were excluded due to a change in surgical procedures after informed consent was obtained. We thereafter analysed data from 260 patients. AF occurred in 83 patients, representing 32% of the overall population. Postoperative day 2 was most common for the initial occurrence of AF (Fig. 1).

Patient data and perioperative characteristics were compared between patients with and without postoperative AF (Table 1). Univariate analysis indicated age, history of paroxysmal AF, average core temperature in the operating room, intraoperative fluid balance, and the average cardiac index in the operating room and in the ICU were all associated with postoperative AF. Multivariate analysis identified advancing age [odds ratio (OR) 1.44 per 10 yr increase, 95% confidence interval (CI) 1.06–1.95], a lower cardiac index in the ICU for the first 12 h (OR 0.37, 95% CI 0.19–0.71), a lower intraoperative fluid balance in the operating room (OR 0.96 per 100 ml increase in intraoperative fluid balance, 95% CI 0.93–0.99), and a higher average core temperature in the operating room (OR 1.64, 95% CI 1.05–2.56) all to be independently associated with postoperative AF (Table 2). The predictive model based on these variables had an area under the receiver operating characteristic curve of 0.73, and the Hosmer–Lemeshow goodness-of-fit statistic suggested a good calibration (P=0.10).

Time to extubation after ICU did not show any significant difference between the patients who suffered postoperative AF [median (inter-quartile range) 4 (2.7–6) h] and those who did not [4 (2.5–5.5) h], P>0.05. Likewise, there was no difference in ICU duration of stay between those with and without AF [38 (20–67) and 30 (15–50) h, respectively, P>0.05]. Patients with postoperative AF took on average 3 days longer before meeting the hospital discharge criteria than those without postoperative AF [10 (7–13) days vs 7 (5–10) days, P<0.01].

Discussion
Many previous studies have investigated the clinical predictors of AF after on-pump CABG. Whereas age is the most consistent predictor of AF after on-pump CABG, other reported predictors vary between studies. Several recent meta-analyses reported that the incidence of postoperative AF was decreased by the use of the off-pump technique.¹⁰⁻¹² These findings suggest that the predictors of AF in off-pump procedures may be different from the ones of conventional on-pump procedure. The major findings in this study show that lower postoperative cardiac index, lower intraoperative fluid balance, relatively higher intraoperative core temperature, and older age contribute to the risk for postoperative AF.

Advanced age was a predictor of postoperative AF in our study. According to previous reports and meta-analyses study,²⁻¹² age is the most consistent predictor of AF. Postoperative AF is thought to arise partially from
the electrophysiological abnormality of the atrial substrate and age-related degenerative changes. Although the present study did not show a significant difference, preoperative electrocardiographic P-wave duration and PR interval were reported to be potential predictors of AF. 13 14 Low cardiac output in the perioperative period was reported to be associated with an increased risk of postoperative AF. 15 However, the evaluation of the cardiac sympathovagal balance before the onset of AF in patients recovering from CABG showed either a higher or lower heart rate variability. 16 These findings indicate that in some patients heightened sympathetic tone is present, but in others, either higher vagal tone or dysfunctional autonomic heart rate control is present before arrhythmia onset. The contribution of intraoperative hypovolaemia to autonomic changes and postoperative AF, however, remains unclear.

Low cardiac output, especially during the early postoperative period, was also a predictor of postoperative AF. Low cardiac output in the perioperative period was reported to be associated with an increased risk of postoperative AF after conventional on-pump CABG. 14 The precise reason is unknown. One possibility is that atrial stretch, secondary to perioperative left ventricular dysfunction, might be related to AF generation. Enhanced

### Table 1 Patient characteristics and perioperative data. Values are shown as mean (range), mean (SD), median [inter-quartile range], or number of patients (%).

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Preoperative</th>
<th>With AF (n=83)</th>
<th>Without AF (n=177)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yr)</td>
<td>71 (41–87)</td>
<td>67 (38–85)</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>Sex (male/female)</td>
<td>62/21</td>
<td>133/44</td>
<td>0.88</td>
<td></td>
</tr>
<tr>
<td>Body mass index (kg m⁻²)</td>
<td>23 (3)</td>
<td>23 (3)</td>
<td>0.54</td>
<td></td>
</tr>
<tr>
<td>Fractal shortening (%)</td>
<td>34 (9)</td>
<td>34 (8)</td>
<td>0.58</td>
<td></td>
</tr>
<tr>
<td>PR interval (ms)</td>
<td>174 (36)</td>
<td>167 (27)</td>
<td>0.11</td>
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</tr>
<tr>
<td>P duration (ms)</td>
<td>110 (18)</td>
<td>110 (17)</td>
<td>0.87</td>
<td></td>
</tr>
<tr>
<td>History of paroxysmal AF (n)</td>
<td>5 (6)</td>
<td>1 (1)</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>Hypertension (n)</td>
<td>50 (60)</td>
<td>107 (60)</td>
<td>0.58</td>
<td></td>
</tr>
<tr>
<td>Diabetes mellitus (n)</td>
<td>36 (43)</td>
<td>80 (45)</td>
<td>0.78</td>
<td></td>
</tr>
<tr>
<td>COPD (n)</td>
<td>10 (12)</td>
<td>35 (20)</td>
<td>0.16</td>
<td></td>
</tr>
<tr>
<td>Neurologic events (n)</td>
<td>6 (7)</td>
<td>13 (7)</td>
<td>0.99</td>
<td></td>
</tr>
<tr>
<td>Hepatic dysfunction (n)</td>
<td>8 (10)</td>
<td>29 (16)</td>
<td>0.18</td>
<td></td>
</tr>
<tr>
<td>Renal dysfunction (n)</td>
<td>5 (6)</td>
<td>18 (10)</td>
<td>0.35</td>
<td></td>
</tr>
<tr>
<td>Peripheral vascular disease (n)</td>
<td>24 (29)</td>
<td>64 (36)</td>
<td>0.29</td>
<td></td>
</tr>
<tr>
<td>Preoperative chronic β-blockade (n)</td>
<td>37 (44)</td>
<td>59 (33)</td>
<td>0.10</td>
<td></td>
</tr>
</tbody>
</table>

### Table 2 Multivariate analysis of postoperative AF

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Odds ratio (95% CI)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (per 10 yr increase)</td>
<td>1.44 (1.06–1.95)</td>
<td>0.0202</td>
</tr>
<tr>
<td>Average cardiac index in ICU for the first 12 h (1 min⁻¹ m⁻²)</td>
<td>0.37 (0.19–0.71)</td>
<td>0.0009</td>
</tr>
<tr>
<td>Fluid balance in OR (per 100 ml increase)</td>
<td>0.96 (0.93–0.99)</td>
<td>0.0074</td>
</tr>
<tr>
<td>Average core temperature in OR (°C)</td>
<td>1.64 (1.05–2.56)</td>
<td>0.0238</td>
</tr>
</tbody>
</table>
inflammatory cytokine production due to cardiac dysfunction might also facilitate AF generation.\textsuperscript{4} Alternatively, in our study, lower cardiac output during the early postoperative period could be secondary to perioperative hypovolaemia, especially as we found, no difference in preoperative cardiac function (\% fractional shortening), preoperative number of coronary vessels with significant stenosis (\geq 50\%), number of distal anastomoses, and duration of surgery between patients with or without postoperative AF.

Intraoperative, relatively higher core temperature was associated with an increased risk of postoperative AF. Previous studies have reported that the incidence of AF is higher after moderate hypothermic cardiopulmonary bypass (CPB) activation.\textsuperscript{5} In our study, lower cardiac output during the early postoperative period could be secondary to perioperative hypovolaemia, especially as we found, no difference in preoperative cardiac function (\% fractional shortening), preoperative number of coronary vessels with significant stenosis (\geq 50\%), number of distal anastomoses, and duration of surgery between patients with or without postoperative AF.

In summary, we documented the predictors of AF after off-pump CABG. Our present findings indicate that some of the known postoperative AF predictors after on-pump CABG also apply to off-pump cases. Further large studies focusing on the postoperative AF predictors in off-pump CABG are needed.

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References

