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 drown 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 technomedical 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

made, it would be wrong to place too much responsibility 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).

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.1,2 We have documented that AF recurs in up to 50% after 2 years, which is in line with other observational studies.3,4 The procedure has a mortality risk of up to 1.5 per thousand,5 and life-threatening complications such as cardiac tamponade or stroke occur in 1–3% of cases.6 Long-term effects beyond 5 years remain unknown. Based on real-world Belgian data, we calculated that one CA–AF on average costs €9600.7 The overall effect of CA–AF is disappointing concerning the fact that the primary aim of CA ideally should be to cure AF.8,9

The 2012 guideline upgrades the aforementioned 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 I-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.

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References

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Questionable levels of evidence in new atrial fibrillation guidelines? Reply

We agree with van Brabandt and his co-authors 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, the recurrence rate after AF ablation is lower compared with antiarrhythmic drug therapy (70 vs. 50%2,5). MANTRA-