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Published in:
HeartRhythm case reports

DOI:
[10.1016/j.hrcr.2015.06.002](https://doi.org/10.1016/j.hrcr.2015.06.002)

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version
Publisher's PDF, also known as Version of record

Publication date:
2015

[Link to publication in University of Groningen/UMCG research database](#)

Citation for published version (APA):

de Maat, G. E., Gerds-Ploeger, H. Z. R., Mariani, M. A., Van Gelder, I. C., Brügemann, J., & Rienstra, M. (2015). Relation of overweight and symptomatic atrial fibrillation: A case report. *HeartRhythm case reports*, 1(5), 342-344. <https://doi.org/10.1016/j.hrcr.2015.06.002>

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Relation of overweight and symptomatic atrial fibrillation: A case report



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Introduction

Over the past few decades, obesity has become a global epidemic and represents a major challenge for current and future health.¹ Although the pathogenesis of atrial fibrillation (AF) is not completely understood, there is compelling evidence that obesity increases the risk for new-onset and recurrences of AF and increases progression to more persistent forms of AF.² Weight reduction in patients with AF reduces the burden and number of AF-episodes and cumulative AF duration.³ These findings support therapy directed at reducing weight and controlling risk factors in the treatment of AF. We present the case of a 46-year-old male patient with symptomatic AF and a temporal relation between weight changes and recurrences of AF.

Case report

A 46-year-old Caucasian male patient with a history of hypertension and 10 years paroxysmal AF was referred to our center. Treatment with class IC and III antiarrhythmic drugs had failed, and the patient experienced progressive frequency and severity of palpitations and fatigue (European Heart Rhythm Association score = 3). The calculated CHA₂DS₂-VASc (acronym for congestive heart failure, hypertension, age ≥ 75 y [double points], diabetes mellitus, prior stroke or thromboembolism [double points], vascular disease, age 65–74 years, sex category) score was 1 (hypertension). The patient's body mass index was 28.3 kg/m² (97 kg, 185 cm) at time of referral. In the workup for pulmonary vein isolation (PVI), transthoracic echocardiography results showed normal cardiac function, and a left atrial volume indexed of 29.1 mL/m². The transcatheter PVI using radio-frequency energy was performed. After the PVI, the patient

lost 10 kg with the help of our institutional patient-tailored 3-month cardiac rehabilitation program, which constituted low-intensity exercise guided by a physiotherapist, a balanced diet supported by our institutional nutritionist, and nutritional psychoeducation provided by a psychologist. Thereafter, the patient was free of atrial arrhythmias during the first 6 months. In the next 6 months, the patient lost another 4 kg, arriving at 83 kg. The variance in the patient's weight over time is depicted in Figure 1. Two years after the first PVI, the patient regained weight up to 98 kg and experienced a symptomatic recurrence of paroxysmal AF, which was confirmed by 24-hour Holter monitoring. A second electrophysiological examination and PVI were scheduled, but with physical exercise the patient managed to lose weight to 89 kg. From that point, he was asymptomatic and in sinus rhythm. The re-PVI was therefore not performed. The patient was in sinus rhythm for over 1 year, until he regained weight up to a total of 100 kg. This time, the recurrent AF episode was classified as persistent, which was confirmed by 24-hour Holter monitoring. The patient underwent elective electrocardioversion, and flecainide was restarted. Another year later, weighing 103 kg, the patient continued to have severely symptomatic AF, with an AF burden on 24-hour Holter monitoring of 39%. The patient was again referred to our cardiac rehabilitation facility; the patient lost 15 kg again, and symptomatic AF disappeared. Since then, neither AF nor other atrial arrhythmias have been seen on 24-hour Holter monitoring.

Discussion

Obesity is associated with multiple cardiovascular risk factors, for example, hypertension, dyslipidemia, insulin resistance, obstructive sleep apnea syndrome, pericardial fat deposition, and a systemic inflammatory state.⁴ After adjustment for other risk factors, obesity and is associated with an increased risk of cardiovascular diseases, such as ischemic heart diseases, heart failure, and AF.⁵ There is abundant evidence for the involvement of obesity in the development of AF. Obese individuals have up to 2.4-fold increased risk for new-onset AF.⁶ The dynamic association

KEYWORDS Atrial fibrillation; Obesity; Risk factors; Pulmonary vein isolation
ABBREVIATIONS AF = atrial fibrillation; PVI = pulmonary vein isolation; SR = sinus rhythm (Heart Rhythm Case Reports 2015;1:342–344)

Conflict of interest: All authors state that there are no conflicts of interest.
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KEY TEACHING POINTS

- Weight reduction and lifestyle management are important in the treatment of symptomatic atrial fibrillation.
- Strict weight management using a cardiac rehabilitation program is a treatment option for obese patients before invasive treatment modalities are deployed.

of weight with AF prevalence was previously presented in the Women's Health Study.⁷ Mechanisms underlying the relation between obesity and new-onset AF, may relate to structural remodeling caused by elevated end-diastolic pressure, inflammation, and increased plasma volume.^{8,9} Also, obesity is known to be associated with sleep apnea syndrome, an independent risk factor for AF.¹⁰

Our case underscores the direct (12-year) temporal relation between weight and symptomatic AF. In this particular case, when weight was >95 kg, the patient experienced symptomatic AF recurrences. All 24-hour electrocardiogram registrations performed, in total 360 hours' worth, are depicted in Figure 1. After testing, no obesity-associated comorbidities, such as diabetes, metabolic syndrome, and sleep apnea syndrome, appeared to be present in our case.

The finding that obesity itself may also induce AF or increase AF burden has been reported in previous studies.¹¹ It is unknown whether this risk factor is attributable only to body composition or also to the level of physical activity.¹² Also, the role of epicardial fat remains to be thoroughly investigated as a risk factor.¹³ Obesity is a modifiable risk factor, although its management can be very challenging in clinical practice. A recent randomized trial compared intervention with active weight management to modification with general lifestyle advice. Results of this pivotal paper show

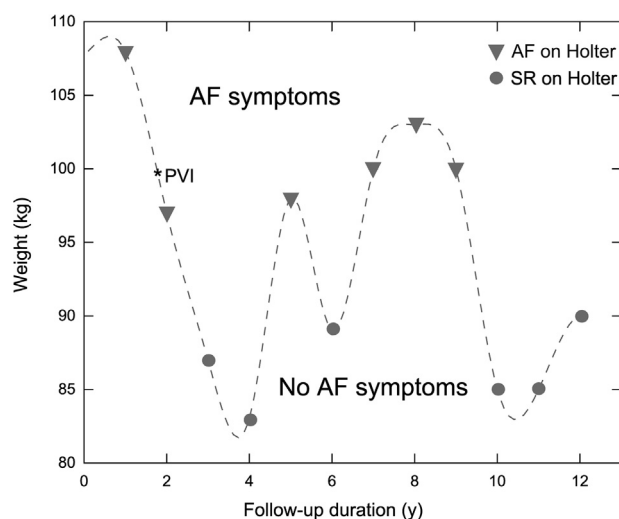


Figure 1 Association between weight and heart rhythm. AF = atrial fibrillation; PVI = pulmonary vein isolation; SR = sinus rhythm.

that weight reduction with intensive risk-factor management causes a significant reduction in AF symptom burden and severity.³ The recent ARREST-AF trial showed that aggressive risk-factor management improves long-term outcomes of AF ablation.¹⁴ Furthermore, if this weight loss is sustained at long-term follow-up, reduction of AF burden and maintenance of sinus rhythm are significantly higher compared to those in patients with weight fluctuation.¹⁵ In fact, our case nicely illustrates the relation of overweight and recurrence of symptomatic AF, and it stresses the importance of weight counseling in patients referred for symptomatic AF, especially before considering invasive treatment modalities such as transcatheter or surgical PVI. A cardiac rehabilitation program is an option for such patients.

Conclusions

Weight reduction and lifestyle management are important in the treatment of symptomatic AF and warrant more attention.

Acknowledgments

We thank Dr. Bastiaan Geelhoed for his contribution to the figure.

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