LOW INCIDENCE OF LEFT ATRIAL APPENDAGE THROMBUS WHEN STOPPING ANTICOAGULATION IN PATIENTS WITH AF WITHOUT BRIDGING PRIOR TO CATHETER ABLATION

ACC Poster Contributions
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Background: The management of pre-procedure anticoagulation in patients with atrial fibrillation (AF) prior to catheter ablation and other invasive procedures differs among institutions. Observational studies have compared bridging with enoxaparin and continuing periprocedural warfarin. Limited information is available on the risks of stopping warfarin without bridging with enoxaparin prior to invasive procedures.

Methods: Patients (Pts) scheduled to receive catheter ablation for AF from Nov 2008 to Dec 2009 were included. As per our protocol, patients stopped warfarin 4-5 days prior to date of procedure and did not receive bridging with enoxaparin or heparin prior to procedure. Each pt received a transesophageal echocardiogram (TEE) prior to catheter ablation to assess for left atrial appendage (LAA) thrombus. Pts were discharged on low dose lovenox as a bridge to warfarin.

Results: A total of 195 pts were enrolled. Most were male (72%) and Caucasian (87%). AF was paroxysmal in 51%, persistent/chronic in 43% and 4% had atrial flutter. CHADS2 score was 0 in 69 (35%), 1 in 80 (41%), 2 in 29 (15%), and 3 or higher in 17 (9%). 191 patients without evidence of clot underwent catheter ablation. Most pts (99%) had normal renal function. 18 n(10%) of pts had EF<50. Four pts (2%) were found to have left atrial thrombus and did not undergo ablation. Of these, 2 were male, 4 Caucasian and 3 had paroxysmal AF. Two had CHADS2 score of 0 and two = 2. These 4 pts resumed anticoagulation without sequelae (however one has <30 day f/up).

Conclusions: The incidence of LAA thrombus formation in patients with AF prior to catheter ablation is low after stopping warfarin without bridging, and no embolic sequelae occurred in this series. Although the risks appear low in most patients, the small risk of thrombus should be considered when discontinuing warfarin therapy prior to AF catheter ablation or other invasive procedures. TEE is appropriate in this setting when or catheterization of the LA or procedural conversion of AF is likely. The safety of this approach for patients who have multiple risk factors for thrombus (CHADS2= 3 or more) requires further study.